

Pinchot Family Medicine, P.C.

New Patient Medical History

Name

First Name _____ Middle Name _____ Last Name _____ Date of Birth _____

MEDICAL HISTORY

Do you currently have....

- | | |
|--|---|
| <input type="checkbox"/> Diabetes Type 2
<input type="checkbox"/> High Blood Pressure
<input type="checkbox"/> High cholesterol
<input type="checkbox"/> Heart disease
<input type="checkbox"/> COPD or emphysema
<input type="checkbox"/> Tobacco Use
<input type="checkbox"/> Obesity or overweight
<input type="checkbox"/> Depression
<input type="checkbox"/> Anxiety
<input type="checkbox"/> GERD
<input type="checkbox"/> Hypothyroid
<input type="checkbox"/> Congestive heart failure | <input type="checkbox"/> Atrial fibrillation
<input type="checkbox"/> Colon polyps
<input type="checkbox"/> History of cancer (If yes, what type?)

<input type="checkbox"/> Arthritis
<input type="checkbox"/> Headaches
<input type="checkbox"/> Liver disease
<input type="checkbox"/> Kidney disease
<input type="checkbox"/> Asthma
<input type="checkbox"/> Environmental Allergies
<input type="checkbox"/> History of stroke or TIA |
|--|---|

List below other health issues you have been treated for in the past:

DRUG ALLERGIES:

Name of Medicine	What was the reaction (rash, short of breath, etc...)
1	
2	
3	
4	

SOCIAL HISTORY

Y N Alcohol Use; If Yes, how much per day? _____

Y N Have you ever used tobacco? If Yes, how much and when
(Describe) _____

FAMILY HISTORY: Please list if a relative has had one of the following conditions:

Y N Colon Cancer	Y N Heart Disease
Y N Prostate Cancer	Y N Stroke
Y N Breast Cancer	Y N Diabetes
Y N Ovarian Cancer	Y N Depression
	Y N Osteoporosis

Please list below any other important conditions that have affected family members:

IMMUNIZATION & HEALTH MAINTENANCE HISTORY

Date of last Tetanus shot _____ Date of Pneumonia Vaccine _____

Most recent colonoscopy _____

Women: Date of Last Pap Test _____

Most recent mammogram _____

CURRENT MEDICATIONS:

Name of Medicine, Dose	How is the medicine taken (once per day, twice per day, etc...)
1	
2	
3	
4	
5	
6	
7	
8	
9	
10	
11	
12	
13	
14	
15	

Nutritional supplements currently taking?

1	3
2	4

PAST SURGERIES AND HOSPITALIZATIONS:

Type of Surgery/Reason for Hospitalization	Year
1	
2	
3	
4	
5	
6	
7	
8	