



Applegate Valley Family Medicine, LLC

NEW PATIENT MEDICAL REVIEW

NAME _____ AGE _____ DATE OF BIRTH _____

What is the main reason you have made this appointment? _____

Marital status (circle one) single married separate divorce widowed partnered child

Name of spouse/partner/parent _____ Spouse/partner's occupation _____

Who is at home with you? _____

Any significant changes in household (divorce, childbirth, etc.)? _____

What is/was your work? _____

Last grade of schooling completed: _____

What recreational interests do you have? _____

(If needed, please attach an additional page to complete the following questions)

MEDICATIONS: List your medications and the dose you take

Name	Pill strength	How often taken	When first begun
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

DRUG ALLERGIES: Which medications can't you take?

Reaction:

_____	_____
_____	_____
_____	_____

PAST MEDICAL HISTORY: If you have had any of these medical problems, please circle them and write in the date you were first told you had that problem.

- | | | | |
|---------------------|----------------------|-----------|----------------------|
| Diabetes | Heart attack | Hepatitis | Cancer (type) |
| High blood pressure | Angina (chest pains) | AIDS | COPD/emphysema |
| Rheumatic fever | High cholesterol | Asthma | Ulcers |
| Heart murmur | Stroke | Arthritis | Hiatal hernia/reflux |

Other medical problems. Please list: _____

Operations: List and give approximate dates. _____

Smoking – current use (packs per day) _____

Past use (or how many years have you smoked?) _____

What was your average pack(s) per day for this time? _____

Alcohol – current use _____

Recreational drugs – current use _____

Current weight _____

Special diet _____
Birth weight (children) _____
Circle: smoking or nonsmoking household
Gestational age (premature/not premature)

Average use in the past _____

Past use: _____

Maximum weight _____

Weight changes over past year _____

FAMILY MEDICAL HISTORY:	if living		if deceased	
	age	health	age at death	cause of death
Father:				
Mother:				
Brothers or sisters:				

Number of children (or siblings) and their ages: _____

Health problems of children? _____

Has any blood relative had any of the following problems? (circle)

diabetes high blood pressure heart attack colon cancer breast cancer other cancer
sudden death other heart disease mental illness

Please CIRCLE any of the conditions you have had OR currently have as a chronic problem:

GENERAL:

unusual fatigue or weakness
chills, fever
bleeding tendency

EYES:

vision loss
blind areas
seeing double

EARS:

hearing loss
ear infections
vertigo/dizziness

THROAT AND MOUTH:

sore mouth, tongue, lips
hoarseness

HEART:

irregular or skipped beats
racing or fluttering
pounding heart phlebitis
chest pain
swollen feet, ankles, hands
murmur

NERVOUS SYSTEM:

dizziness
blackout spells
little strokes (TIA's)
numbness or tingling
paralysis
seizures

BONES, JOINTS, MUSCLES:

painful or stiff joints
back pain
cramps in muscles of legs
varicose veins

SKIN:

skin cancer itching
hair loss rash

BREAST:

lump or discharge

LUNGS:

persistent cough
coughing up blood, pus, mucus
shortness of breath
wheeze
sit up to breathe

STOMACH AND INTESTINES:

difficulty swallowing
frequent indigestion or heartburn
nausea/vomiting
diarrhea/constipation
black stools
abdominal pain/stomachache

jaundice (yellow skin)
pancreatitis
gallbladder disease

GENITO-URINARY:

pain or burning on urination
night frequency (excessive)
slow starting or stopping
discharge, bloody or dark urine

kidney stones
impotence
loss of libido (sex drive)
syphilis, gonorrhea or Chlamydia

MOODS/PSYCHIATRIC:

lack of memory
depression
anxiety
nervous breakdown
extreme mood swings/bipolar disorder
other mental condition

alcoholism
drug dependence, addiction

MENSTRUAL/GYNECOLOGICAL:

bleeding after intercourse
abnormal vaginal bleeding
abnormal Pap smear
hot flashes/night sweats

date of last period:

ABUSE: (Are you unsafe in any way?)

physical verbal
emotional sexual

DATE OF LAST COMPLETE PHYSICAL EXAM _____ PAP SMEAR _____ PROSTATE EXAM _____

TETANUS SHOT _____ PNEUMONIA SHOT _____ MAMMOGRAM _____ COLONOSCOPY _____

SIGNATURE _____ DATE COMPLETED _____