FLOMATON MEDICAL CENTER

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Attention: Due to new government regulations, we are not accepting any new pain medication patients.

New Patient Medical History - Please complete this entire form prior to your first appointment

Name: ______________________________ Date of Birth: ___/___/ ___ Age: ____ Sex: ____

♦ Please briefly state in the box below the reason for your visit ♦

• Has a previous Provider provided treatment for the reason you are being seen today?
If yes, please provide Provider information. ______________________________

Preferred Local Pharmacy: ______________________________
(Address/City)
Do you use a mail order pharmacy? ____________ If so, please be sure we have your pharmacy provider information and a copy of your prescription drug card.
Preferred Mail Order Pharmacy: ______________________________
Should your information change, please report these changes in your address, phone contact numbers, insurance, or emergency contact, information to the front desk upon check in at future visits

♦ Past Medical History ♦

Condition / Disease	*Year Began*	*Condition / Disease*	*Year Began*
❑ Hypertension		Other(s):	
❑ High Cholesterol			
❑ Hypothyroidism (low thyroid)			
❑ COPD, Emphysema or Asthma			
❑ Diabetes			
❑ GERD			
❑ Depression or Anxiety			
❑ Heart Problems -			

♦ Past Surgical Procedures / Hospitalizations / Serious Injuries or Fractures ♦

Operation / Hospitalization / Injury	*Month / Yr*	*Operation / Hospitalization / Injury*	*Month / Yr*

□ Do you currently **follow up with any other Provider/Specialist?** (Example: Cardiology, Neurology, Urology, Endocrinology, Infection disease, Mental Health, Nephrology, Therapy, Optometry, Orthopedics, ENT.)

If so please list the provider(s) you are following up with:

♦ Other Physicians and Specialists ♦

List below your other physicians (i.e., Gyn, Dermatology, GI, Orthopedics, Urology, Psychiatry, etc)

♦ Medication or Food Allergies or Intolerances ♦

List below medications or foods causing an allergic reaction (i.e., rash, swelling) or intolerance (i.e., nausea)

Medication / Food	***Reaction***	***Medication / Food***	***Reaction***

♦ Medications, Vitamins and Herbal Supplements ♦

Medication	***Strength***	***Number of pills taken & frequency***	***Medication***	***Strength***	***Number of pills taken & frequency***
Example: *Tylenol*	*500 mg*	*1 - twice daily*			

♦ Social, Educational and Work History ♦

Marital Status:	Age of children, if any:	
Work Status (circle one): Employed Unemployed / Retired / Disabled	Current or Prior Occupation:	Hours worked per week:
Highest Level of Education:	Completed at which institution / school:	
What type of exercises do you perform, duration & frequency?		
In what type of residence do you live (i.e., house, assisted living, nursing home)?		
What are your hobbies?		
Do you drink alcohol?	What type of alcohol?	No. of drinks per week?
Are you a current smoker?	If you smoke, how many packs per day?	
Are you a former smoker?	If so, what year did you quit?	No. of years you smoked?
On average, how much did you smoke per day?		
Are you sexually active: Yes / No	Do you have sex with: Men / Women / Both	How many partners have you had during the past 12 months?
Are you concerned that you may have been exposed to HIV? Yes / No		

♦ Family Health History ♦

Please list below the health history of your blood (genetic) first degree relatives

Relative	***Living or Deceased***	***Current age or age at death***	***Cause of Death***	***Health Problems***
Father:				
Mother:				
Brother(s):				
Sister(s):				

♦ Review of Systems ♦

Please review the following symptoms and ***check*** *those items that have been a problem for you in the past and* ***circle*** *the ones that are a problem for you today*

Vision problems	Wheezing	Lumps in breast	Frequent Urination	Excessive hunger
Hearing problems	Asthma / COPD	Breast discharge	Incontinence	Excessive thirst
Sinus trouble	Emphysema	Trouble swallowing	Blood in Urine	Weakness
Hay fever	Bronchitis	Nausea	History of STD's	Fatigue
Nosebleeds	TB exposure	Vomiting	Anemia	Fever / Sweating
Sore throat	Chest pain	Abdominal pain	Easy bruising	Fainting
Hoarseness	Chest discomfort	Hepatitis / Jaundice	Pain in legs	Seizures / Tremor
Lumps in neck	Shortness of breath	Gallstones	Joint pain / stiffness	Headaches
Tooth problems	High blood pressure	Diarrhea	Blood clot	Numbness/tingling
Cough	Diabetes	Constipation	Weight loss / gain	Anxiety/Depression
Coughing blood	High cholesterol	Blood in stool	Heat/cold intolerance	Difficulty sleeping

- ❑ ***Place an "X" in the box to the left if you have none of the above.***

♦ Disease Prevention and Health Maintenance ♦

Please list below the most recent dates of your vaccines and health screening tests

	Month/Yr		***Month/Yr***		***Month/Yr***
Flu Vaccine		Mammogram-female		Eye Exam	
Pneumonia Vaccine		Sleep Study		EEG	
Tetanus Vaccine		Pap Smear-female		Heart Catheterization	
Hepatitis B Vaccine		Colonoscopy		Endoscopy (EGD)	
Shingles Vaccine		Bone Density		Heart Stress Test	
Gardasil Vaccine		EKG		Abdominal Aneurysm Screen	
Cardiac Echo		Chest X-Ray		HIV Test	
CT screening for lung cancer-smokers/former smoker		Spirometry/PFT			