

# Family Medicine East Chtd

1709 S Rock Rd    Wichita, KS 67207    Phone (316) 682-7411

**New Patient Medical History - Please complete this two-sided form prior to your first appointment**

Name: _____	Date of Birth: ___/___/___
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<b>◆ Please briefly state in the box below the reason for your visit ◆</b>

<b>◆ Past Medical History ◆</b>			
<i>Condition / Disease</i>	<i>Year Began</i>	<i>Condition / Disease</i>	<i>Year Began</i>
<input type="checkbox"/> Hypertension		Other(s):	
<input type="checkbox"/> High Cholesterol			
<input type="checkbox"/> Hypothyroidism (low thyroid)			
<input type="checkbox"/> COPD, Emphysema or Asthma			
<input type="checkbox"/> Diabetes			
<input type="checkbox"/> GERD			
<input type="checkbox"/> Depression or Anxiety			
<input type="checkbox"/> Heart Problems -			

<b>◆ Past Surgical Procedures / Hospitalizations / Serious Injuries or Fractures ◆</b>			
<i>Operation / Hospitalization / Injury</i>	<i>Month / Yr</i>	<i>Operation / Hospitalization / Injury</i>	<i>Month / Yr</i>

<b>◆ Other Physicians and Specialists ◆</b>
<i>List below your other physicians (i.e., Gyn, Dermatology, GI, Orthopedics, Urology, Psychiatry, etc)</i>

<b>◆ Medication / Food Allergies / Intolerances ◆</b>			
<i>List below medications or foods causing an allergic reaction (i.e., rash, swelling) or intolerance (i.e., nausea)</i>			
<i>Medication / Food</i>	<i>Reaction</i>	<i>Medication / Food</i>	<i>Reaction</i>

<b>◆ Medications, Vitamins and Herbal Supplements ◆</b>					
<i>Medication</i>	<i>Strength</i>	<i>Number of pills taken &amp; frequency</i>	<i>Medication</i>	<i>Strength</i>	<i>Number of pills taken &amp; frequency</i>
<i>Example: Tylenol</i>	<i>500 mg</i>	<i>1 - twice daily</i>			

**◆ Social History ◆**

Age of children, if any:		
In what type of residence do you live (i.e., house, assisted living, nursing home)?		
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	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 circle those items that are a problem for you*

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*

	<i>Month/Yr</i>		<i>Month/Yr</i>		<i>Month/Yr</i>
Flu Vaccine		Mammogram		Eye Exam	
Pneumonia Vaccine		Pap Smear		Heart Catheterization	
Tetanus Vaccine		Colonoscopy		Endoscopy (EGD)	
Hepatitis B Vaccine		Bone Density		Heart Stress Test	
Shingles Vaccine		EKG		Ab Aneurysm Screen	
Gardasil Vaccine		Chest X-Ray		HIV Test	