FAMILY DOCTORS OF VICKSBURG PC
13320 NORTH BOULEVARD ST. VICKSBURG MI 49097 269-649-2012 FAX: 269-649-3752

NEW PATIENT HISTORY

Date: _____ Name: _____ DOB: _____
Marital Status: ___Single ___Engaged ___Married/Partnered for how long _____/years
___Separated ___Divorced for how long _____/years ___Widowed for how long _____/years

Highest grade completed in school (or degree) _____
Do you work outside the home? _____ What kind of work do you do? _____
Have you ever worked with hazardous material or toxins? _____

Do you attend religious services? _____ Where? _____
Is prayer important to you? _____ Do you feel comfortable talking about spirituality with your doctor? _____

Please list any concerns you have: _____
_____

List all Hospitalizations

YEAR	HOSPITAL	DIAGNOSIS

List all Operations

YEAR	HOSPITAL	OPERATION

List all medications you are currently taking (including over the counter and herbal)

MEDICATION	DOSE	HOW OFTEN

MEDICATION	DOSE	HOW OFTEN

List all allergies to medications

MEDICATION	REACTION YOU HAVE

MEDICATION	REACTION YOU HAVE

Social History

Have you ever used tobacco? Yes / No
If YES: Average packs per day _____ Number of years you smoked _____ The year you quit _____
If you have not quit, when are you planning to quit? Now 6 months Sometime Never

Do you drink alcohol? Yes / No

If YES	Y	N
Have you ever felt you should cut down?		
Have people ever annoyed you by nagging about your drinking?		
Have you ever felt guilt about your drinking?		
Have you ever had a drink first thing in the morning?		
Has drinking ever affected your job performance?		
Have you ever drank and driven a vehicle?		

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Prevention:

Which of the following are included in your diet?

	Grains	Veggies	Dairy	Meats	Sweets
A lot					
Some					
Few					

Do you have a grandparent, parent, sibling or child with a history of the following?

	Who?		Who?
Uterine Cancer		Glaucoma	
Ovarian Cancer		Osteoporosis/hip fracture	
Breast Cancer		Alcoholism	
Colon Cancer		Depression	
Skin Cancer		Aneurysm	
Heart attack/stent/bypass			

Have there been any of these changes in your family? Birth___ Marriage/Divorce ___ Death ___ Job change ___
Do you exercise? Yes ____ No ____ Activity _____ Number of days per week _____
Time/duration _____ minutes/hours _____ Exertion: Stroll / Mild / Heavy
Do you always wear seat belts? Yes / No Does your house have a working smoke detectorYes / No
Do you have firearms at home? Yes / No
If over 30 years old, has your cholesterol level checked in the past 10 years? Yes / No
How many sexual partners have you had in the last: 12 months _____ Lifetime _____
When was your last dental check-up? _____
Do you take over the counter weight loss or body building substances? Yes _____ No _____
Do you now have:

Y	N	Unsure	CONST
			Weight change
			Loss of appetite
			Problem sleeping
			DERM
			Changing mole
			Sore that won't heal
			Rash
			EYES
			Double vision
			Wear glasses/contacts
			Eye pain
			"red eyes"
			Lots of "floaters"
			ENT
			Hearing loss
			Balance problems
			Recurrent sinus/nasal congestion
			Swelling in the neck
			CARDIOVASCULAR
			Wake up at night short of breath
			Legs swell at end of day
			Chest discomfort when you walk
			Heart pounds or skips a beat
			Have you fainted/passed out

Y	N	Unsure	GI
			Use antacids frequently
			Does food get stuck when you swallow
			Black or bloody stools
			Constipation
			Abdominal pain
			Recurrent diarrhea
			ENDO
			Do you feel hotter or colder than others?
			Increased thirst?
			MUSCULOSKELETAL
			Pain in legs when walking
			Joint pain
			Back pain
			Inflamed leg veins
			HEME/ONC
			Night sweats
			Unusual bleeding or bruising
			New lumps or bumps
			ALLERGY
			Itchy/watery eyes
			Sneezing
			What time of the year do these appear?
			NEUROLOGY
			New headache

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			RESPIRATORY
			Chronic cough
			Cough up blood
			Shortness of breath at rest
			Shortness of breath walking
			GU
			Problems with erections
			Burning with urination
			Loss of bladder control
			Blood in urine
			Trouble starting to urinate
How many times do you urinate at night?			

			Frequent headaches
			Numbness
			Tingling
			PSYCH
			Panicky feeling
			Trouble remembering things
			Feel depressed
			Wake up frequently at night
			Nervousness/worries

FOR WOMEN ONLY (MEN SKIP TO BOTTOM OF THE PAGE)

Y	N	Unsure	
			Problems with present method of birth control
			Bleeding between periods or since periods stopped
			Pain with intercourse or periods
			Any problem with interest in or enjoying intercourse
			A new or enlarging lump in breast
			Conflict in family or relationships, sometimes handled by pushing, hitting or cruelty
			Are you afraid to return to your current living situation

When was the first day of your last period (or last year of menstruation if postmenopausal) _____
Number of times pregnant: ____ Number of completed pregnancies: ____ Date of last pregnancy: _____
If you are under age 55; what method of birth control do you use? _____
If you are through menopause or over age 50 do you take any of the following pills?
____Calcium ____Vitamin D ____Hormone Replacement Therapy
Have you ever had an abnormal pap smear? __Yes __No If yes, date: _____ problem: _____
For abnormality did you have any of the following done:
_____Colposcopy _____Biopsy _____Surgery
When was your last: Mammogram: _____ results: _____
Pap smear _____ results: _____Bone Density: _____ results: _____

FOR MEN AND WOMEN:

When was your last:	Date	Normal	Abnormal	If abnormal, what was the result?
Colonoscopy/Flexible Sigmoidoscopy:	_____	____	_____	_____
EKG	_____	____	_____	_____
PSA (male only)	_____	____	_____	_____

Tetanus Shot: _____ Influenza Shot: _____ Pneumococcal Shot: _____

Do you see any specialists? Yes _____ No _____

If yes, please list the doctor/their specialist and the medical condition you are being treated for:

Doctor Specialty Medical Condition
_____
_____
_____
_____