# Healing Hands Integrated Wellness & Primary Care
# NEW PATIENT MEDICAL HISTORY FORM

Full Name: _____ Date: _____

Birth Date: _____ Age: _____

## ALLERGIES ❑ NO ALLERGIES

| ALLERGY | ALLERGIC REACTION |
|---|---|
| | |
| | |
| | |
| | |

## MEDICATIONS

| MEDICATIONS *(Please list ALL)* | DOSE *(Mg., pill, etc.)* | TIMES PER DAY |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

*If you need more room to list medications, please write them on a blank sheet of paper with the required information*

## HEALTH MAINTENANCE SCREENING TEST HISTORY

| | | | |
|---|---|---|---|
| **CHOLESTEROL** | Date: | Facility/Provider: | Abnormal Result? Y N |
| **COLONOSCOPY/SIGMOID** | Date: | Facility/Provider: | Abnormal Result? Y N |
| **MAMMOGRAM** | Date: | Facility/Provider: | Abnormal Result? Y N |
| **PAP SMEAR** | Date: | Facility/Provider: | Abnormal Result? Y N |
| **BONE DENSITY** | Date: | Facility/Provider: | Abnormal Result? Y N |

## VACCINATION HISTORY

| | |
|---|---|
| Last Tetanus Booster or TdaP: | Last Pnuemovax *(Pneumonia)*: |
| Last Flu Vaccine: | Last Prevnar: |
| Last Zoster Vaccine *(Shingles)*: | |

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## PERSONAL MEDICAL HISTORY

| DISEASE/CONDITION | CURRENT | PAST | COMMENTS |
|---|---|---|---|
| Alcoholism/Drug Abuse | | | |
| Asthma | | | |
| Cancer *(type:_____)* | | | |
| Depression/Anxiety/Bipolar/Suicidal | | | |
| Diabetes *(type:_____)* | | | |
| Emphysema *(COPD)* | | | |
| Heart Disease | | | |
| High Blood Pressure *(hypertension)* | | | |
| High Cholesterol | | | |
| Hypothyroidism/Thyroid Disease | | | |
| Renal *(kidney)* Disease | | | |
| Migraine Headaches | | | |
| Stroke | | | |
| Other: | | | |
| Other: | | | |

## SURGERIES

| **TYPE** *(specify left/right)* | DATE | LOCATION/FACILITY |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

## WOMEN'S HEALTH HISTORY

| | |
|---|---|
| Date of Last Menstrual Cycle: | Age of First Menstruation: _____ Age of Menopause: _____ |
| Total Number of Pregnancies: | Number of Live Births: |
| Pregnancy Complications: | |

Patient Name: _____ DOB: _____

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## FAMILY MEDICAL HISTORY ❑ NO SIGNIFICANT FAMILY HISTORY IS KNOWN

| ✔ CHECK ALL THAT APPLY | Alcohol/Drug Abuse | Asthma | Cancer (type:_____) | Emphysema (COPD) | Depression/Anxiety | Bipolar/Suicidal | Diabetes | Early Death | Heart Disease | High Cholesterol | High Blood Pressure | Kidney Disease | Stroke | Thyroid Disease | Migraines | Other:_____ | Other:_____ | Other:_____ |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Mother | | | | | | | | | | | | | | | | | | |
| Father | | | | | | | | | | | | | | | | | | |
| Brother | | | | | | | | | | | | | | | | | | |
| Sister | | | | | | | | | | | | | | | | | | |
| Child | | | | | | | | | | | | | | | | | | |
| MGM | | | | | | | | | | | | | | | | | | |
| MGF | | | | | | | | | | | | | | | | | | |
| PGM | | | | | | | | | | | | | | | | | | |
| PGF | | | | | | | | | | | | | | | | | | |
| Other:_____ | | | | | | | | | | | | | | | | | | |

## SOCIAL HISTORY

| | |
|---|---|
| Occupation *(or prior occupation)*: | ❑ Retired ❑ Unemployed ❑ LOA ❑ Disabled |
| Employer: | Years of Education or Highest Degree: |
| If employed, do you work the night shift? Y N N/A | |
| Marital Status *(check one)*: ❑ Single ❑ Partner ❑ Married ❑ Divorced ❑ Widowed ❑ Other:_____ | |
| Do you have children? Y N | If yes, how many? |

## OTHER HEALTH ISSUES

| | | | |
|---|---|---|---|
| **TOBACCO USE** | Smoke Cigarettes? Y N *(If you never smoked, please move to Alcohol /Drug Use)* | | |
| ***Current:*** Packs/day _____ # of Years _____ | ***Past:*** Quit Date: _____ Packs/day _____ # of Years _____ | | |
| Other Tobacco *(check one)*: ❑ Pipe ❑ Cigar ❑ Snuff ❑ Chew | | | |
| **ALCOHOL/DRUG USE** | Do you drink alcohol? Y N | ❑ Beer ❑ Wine ❑ Liquor | # of Drinks/week: |
| Do you use marijuana or recreational drugs? Y N | Have you ever used needles to inject drugs? Y N | | |
| Have you ever taken someone else's drugs? Y N | | | |

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## OTHER HEALTH ISSUES continued...

| | | |
|---|---|---|
| **SEXUAL ACTIVITY** | Sexually involved currently? Y N *(If no sexual history, please continue to Exercise)* | |
| Sexual partner(s) is/are/have been: ❑ Male ❑ Female | | |
| Birth control method: ❑ None ❑ Condom ❑ Pill/Ring/Patch/Inj/IUD ❑ Vasectomy | | |
| **EXERCISE** | Do you exercise regularly? Y N *(If you answered no, please move to Sleep)* | |
| What kind of exercise? | ***Duration:*** How long (min.): _____ How often: _____ | |
| **SLEEP** | How many hours, on average, do you sleep at night *(or during the day, if working night shift)*? | |
| **DIET** | How would you rate your diet? ❑ Good ❑ Fair ❑ Poor | Would you like advice on your diet? Y N |
| **SAFETY** | Do you use a bike helmet? Y N | Do you use seat belts consistently? Y N |
| Working smoke detector in home? Y N | | If you have guns at home, are they locked up? Y N |
| Is violence at home a concern for you? Y N | | Have you completed an Advance Directive for Health Care (ADHC), Living Will, or Physical Orders for Life Sustaining Therapy (POLST)? Y N |

## OTHER PROVIDERS/SPECIALISTS

| SPECIALIST | NAME | LAST VISIT |
|---|---|---|
| Cardiology | | |
| Gastroenterologist (GI) | | |
| OB/GYN | | |
| Neurology | | |
| Pulmonary | | |
| Other:_____ | | |
| Other:_____ | | |

## ADDITIONAL INFORMATION

| | |
|---|---|
| Have you traveled outside of the country in the last 30 days? Y N | If yes, where? |
| Have you served in the military? Y N | If yes, how long and what branch? |
| Were you deployed? Y N | If yes, where? |

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# REVIEW OF SYSTEMS ✔ CHECK ALL THAT APPLY

| CONSTITUTION | CARDIOVASCULAR | SKIN |
|---|---|---|
| Activity change | Chest pain | Color change |
| Appetite change | Leg swelling | Pallor |
| Chills | Palpitations | Rash |
| Diaphoresis | **Gastrointestinal** | Wound |
| Fatigue | Abdominal distention | **ALLERGY/IMMUNO** |
| Fever | Abdominal pain | Environmental allergies |
| Unexpected weight change | Anal bleeding | Food allergies |
| **HEAD, EAR, NOSE & THROAT** | Blood in stool | Immunocompromised |
| Congestion | Constipation | **NEUROLOGICAL** |
| Dental problem | Diarrhea | Dizziness |
| Drooling | Nausea | Facial asymmetry |
| Ear discharge | Rectal pain | Headaches |
| Ear pain | Vomiting | Light-headedness |
| Facial swelling | **ENDOCRINE** | Numbness |
| Hearing loss | Cold intolerance | Seizures |
| Mouth sores | Heat intolerance | Speech difficulty |
| Nosebleeds | Polydipsia | Syncope |
| Postnasal drip | Polyphagia | Tremors |
| Rhinorrhea | Polyuria | Weakness |
| Sinus pressure | **Genitourinary** | **HEMATOLOGIC** |
| Sneezing | Difficulty urinating | Adenopathy |
| Sore throat | Dysuria | Bruises/bleeds easily |
| Tinnitus | Enuresis | **PSYCHIATRIC** |
| Trouble swallowing | Flank pain | Agitation |
| Voice change | Frequency | Behavior problem |
| **EYES** | Genital sore | Confusion |
| Eye discharge | Hematuria | Decreased concentration |
| Eye itching | Penile discharge | Dysphoric mood |
| Eye pain | Penile pain | Hallucinations |
| Eye redness | Penile swelling | Hyperactive |
| Photophobia | Scrotal swelling | Nervous/anxious |
| Visual disturbance | Testicular pain | Self-injury |
| **RESPIRATORY** | Urgency | Sleep disturbance |
| Apnea | Urine decreased | Suicidal ideas |
| Chest tightness | **MUSCULAR** | |
| Choking | Arthralgias | |
| Cough | Back pain | |
| Shortness of breath | Gait problems | |
| Stridor | Joint swelling | |
| Wheezing | Myalgias | |
| | Neck pain | |
| | Neck stiffness | |

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