Outpatient Medical Center, Inc.
New Patient Medical History Questionnaire

Patient Name: _____ **Date:** _____

Instructions: Please fill out as much as you can and give to nurse when you are called.

Drug Allergies

Are you allergic to any medications? ☐ **No** ☐ **Yes** If yes, please list them & your reaction:

_____

Have you had a recent ER, Urgent Care, Hospital visit? ☐ **No** ☐ **Yes** If yes, where:

_____

Past Medical History: (Please Check All That Apply)

	NO	YES	TYPE		NO	YES	TYPE
ADD / ADHD	☐	☐	_____	Hepatitis	☐	☐	_____
Allergies	☐	☐	_____	High Blood Pressure	☐	☐	_____
Anemia	☐	☐	_____	High Cholesterol / Lipids	☐	☐	_____
Anxiety	☐	☐	_____	HIV / Aids	☐	☐	_____
Arthritis / Gout	☐	☐	_____	Insomnia / Sleep Problems	☐	☐	_____
Asthma / COPD	☐	☐	_____	Kidney Infection / Stones	☐	☐	_____
Bleeding Disorder/Blood Clots	☐	☐	_____	Neuropathy	☐	☐	_____
Cancer	☐	☐	_____	Pain	☐	☐	_____
Circulatory Problems	☐	☐	_____	Pneumonia	☐	☐	_____
Constipation	☐	☐	_____	Psychiatric / Depression	☐	☐	_____
Diabetes	☐	☐	_____	Rectal Bleeding	☐	☐	_____
Diarrhea	☐	☐	_____	Reflux / Heartburn / Ulcer	☐	☐	_____
Difficulty Hearing	☐	☐	_____	Seasonal Allergies	☐	☐	_____
Diverticulitis / Diverticulosis	☐	☐	_____	Seizures	☐	☐	_____
Eye Disease	☐	☐	_____	Sexually Transmitted Diseases	☐	☐	_____
Gallstones / Liver Disease	☐	☐	_____	Thyroid Problems	☐	☐	_____
Headaches	☐	☐	_____	Tuberculosis	☐	☐	_____
Heart Disease/ Irregular Beat	☐	☐	_____	Vitamin Deficiency	☐	☐	_____
Hemorrhoids	☐	☐	_____	Other: _____			_____

Past Surgical / Hospitalization History

	NO	YES	Date		NO	YES	Date
Gallbladder	☐	☐	_____	Pacemaker/Defibrillator	☐	☐	_____
Orthopedic	☐	☐	_____	Other: _____			_____
Tonsils/Adenoids	☐	☐	_____				

Social History

Do you drink alcohol? ☐ **No** ☐ **Yes** If yes, how much? _____

Do you use tobacco? ☐ **No** ☐ **Yes** If yes, how much? _____

Do you use marijuana or other drugs? ☐ **No** ☐ **Yes** If yes, what kind and how much? _____

Family History: **(Please List Any Immediate Family Members Who Have or Had A History of Illness or Cancer and Their Relationship to The Patient)**

_____

_____

_____

_____

Medications: (Please Include Over The Counter)			
Medication	**Strength**	**How Often**	**Purpose**

Vaccines: (Please Write Most Recent Date Received)	Wellness Screening			
		NO	**YES**	**DATE**
COVID: _____	PAP Smear	☐	☐	_____
Flu: _____	Colonoscopy	☐	☐	_____
Hep B: _____	Eye Exam	☐	☐	_____
Pneumococcal: _____	Mammogram	☐	☐	_____
Shingles: _____	TB Test	☐	☐	_____
Tetanus: _____				

Men's Health

Any prostate problems? ☐ **No** ☐ **Yes** If yes, please explain: _____

Do you suffer from erectile dysfunction? ☐ **No** ☐ **Yes**

Women's Health

Are you currently pregnant? ☐ **No** ☐ **Yes**

Do you use contraception? ☐ **No** ☐ **Yes** **Type:** _____

Have you ever had a caesarean section (C-section)? ☐ **No** ☐ **Yes** If yes, when? _____

Have you ever had a tubal ligation? ☐ **No** ☐ **Yes** If yes, when? _____

Have you had a hysterectomy? ☐ **No** ☐ **Yes** If yes, when? _____

Are you post-menopausal? ☐ **No** ☐ **Yes**

Do you have osteoporosis? ☐ **No** ☐ **Yes**

Have you ever had Hormone Replacement Therapy? ☐ **No** ☐ **Yes**

Do you have frequent infections? ☐ **No** ☐ **Yes** **Type:** _____

Do you have a lump in your breast? ☐ **No** ☐ **Yes** **Type:** _____

Do you have a family history of the following? If so, please list family relationship to patient.

☐ **Breast Cancer** _____ ☐ **Ovarian Cancer** _____