



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? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, please list them & your reaction: _____ _____

Past Medical History: (Please Check All That Apply)							
	NO	YES	TYPE		NO	YES	TYPE
ADD / ADHD	<input type="checkbox"/>	<input type="checkbox"/>	_____	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Allergies	<input type="checkbox"/>	<input type="checkbox"/>	_____	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	_____	High Cholesterol / Lipids	<input type="checkbox"/>	<input type="checkbox"/>	_____
Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	_____	HIV / Aids	<input type="checkbox"/>	<input type="checkbox"/>	_____
Arthritis / Gout	<input type="checkbox"/>	<input type="checkbox"/>	_____	Insomnia / Sleep Problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
Asthma / COPD	<input type="checkbox"/>	<input type="checkbox"/>	_____	Kidney Infection / Stones	<input type="checkbox"/>	<input type="checkbox"/>	_____
Bleeding Disorder/Blood Clots	<input type="checkbox"/>	<input type="checkbox"/>	_____	Neuropathy	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____	Pain	<input type="checkbox"/>	<input type="checkbox"/>	_____
Circulatory Problems	<input type="checkbox"/>	<input type="checkbox"/>	_____	Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>	_____
Constipation	<input type="checkbox"/>	<input type="checkbox"/>	_____	Psychiatric / Depression	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____	Rectal Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	_____	Reflux / Heartburn / Ulcer	<input type="checkbox"/>	<input type="checkbox"/>	_____
Difficulty Hearing	<input type="checkbox"/>	<input type="checkbox"/>	_____	Seasonal Allergies	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diverticulitis / Diverticulosis	<input type="checkbox"/>	<input type="checkbox"/>	_____	Seizures	<input type="checkbox"/>	<input type="checkbox"/>	_____
Eye Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____	Sexually Transmitted Diseases	<input type="checkbox"/>	<input type="checkbox"/>	_____
Gallstones / Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____	Thyroid Problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	_____	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart Disease/ Irregular Beat	<input type="checkbox"/>	<input type="checkbox"/>	_____	Vitamin Deficiency	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hemorrhoids	<input type="checkbox"/>	<input type="checkbox"/>	_____	Other: _____			_____

Past Surgical / Hospitalization History							
	NO	YES	Date		NO	YES	Date
Gallbladder	<input type="checkbox"/>	<input type="checkbox"/>	_____	Pacemaker/Defibrillator	<input type="checkbox"/>	<input type="checkbox"/>	_____
Orthopedic	<input type="checkbox"/>	<input type="checkbox"/>	_____	Other: _____			_____
Tonsils/Adenoids	<input type="checkbox"/>	<input type="checkbox"/>	_____				

Social History
Do you drink alcohol? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, how much? _____
Do you use tobacco? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, how much? _____
Do you use marijuana or other drugs? <input type="checkbox"/> No <input type="checkbox"/> 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

Vaccines: (Please Write Most Recent Date Received)	Wellness Screening		
	NO	YES	DATE
COVID: _____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Flu: _____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hep B: _____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Pneumococcal: _____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Shingles: _____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Tetanus: _____	<input type="checkbox"/>	<input type="checkbox"/>	_____

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 _____