GEM FAMILY MEDICINE
and Pregnancy Care

NEW PATIENT MEDICAL HISTORY

PATIENT NAME: _____ **DATE OF BIRTH:** _____

ALLERGIES: List all allergies (medications, food, bee stings, etc.) and how it affects you.

ALLERGY:	REACTION:
1._____	_____
2._____	_____
3._____	_____

MEDICATIONS: List all medications you are taking. Include prescribed drugs and over-the-counter drugs, such as vitamins and inhalers.

DRUG NAME:	STRENGTH:	FREQUENCY TAKEN:
1._____	_____	_____
2._____	_____	_____
3._____	_____	_____
4._____	_____	_____
5._____	_____	_____
6._____	_____	_____
7._____	_____	_____
8._____	_____	_____
9._____	_____	_____
10._____	_____	_____

IMMUNIZATIONS: Check all immunizations that apply and the date you received them.

- ☐ Flu Shot Date: _____
- ☐ Pneumonia Date: _____
- ☐ Tdap (*Tetanus and Pertussis*) Date: _____
- ☐ Tetanus Date: _____
- ☐ Zostavax (*Shingles*) Date: _____

OBSTETRIC AND GYNECOLOGICAL HISTORY (women only)

1. Date of last PAP Smear: _____ Abnormal? Y / N
2. Date of last Mammogram: _____ Abnormal? Y / N

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PAST MEDICAL HISTORY: Check all that apply.

- ☐ Anxiety Disorder
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorder
- ☐ Blood Clots (or DVT)
- ☐ Cancer: _____
- ☐ Coronary Artery Disease
- ☐ Diabetes: Insulin
- ☐ Diabetes: Non-Insulin
- ☐ Dialysis
- ☐ Diverticulitis
- ☐ Fibromyaligia
- ☐ Gout
- ☐ Have a Pacemaker
- ☐ Heart Attack: _____ (date)
- ☐ Heart Murmur
- ☐ Hiatal Hernia/Reflux Disease
- ☐ HIV or AIDS
- ☐ High Cholesterol
- ☐ High Blood Pressure
- ☐ Kidney Disease
- ☐ Kidney Stones
- ☐ Leg/Foot Ulcers
- ☐ Liver Disease
- ☐ Osteoporisis
- ☐ Polio
- ☐ Pulmonary Embolism
- ☐ Reflux or Ulcers
- ☐ Stroke
- ☐ Thyroid issues
- ☐ Tuberculosis
- ☐ OTHER: _____ _____

PAST SURGICAL HISTORY: List type, date, and location of any previous surgeries.

SURGERY:	YEAR:	HOSPITAL/LOCATION:
1._____	_____	_____
2._____	_____	_____
3._____	_____	_____

SOCIAL HISTORY: Check all that apply.

1. Caffeine: ☐ None ☐ Occasional ☐ Moderate ☐ Heavy # of drinks/day:_____
2. Tobacco: Do you use tobacco? Y / N If not currently, have you ever used it? Y / N
   For how many years? _____ If you quit, what year did you quit? _____
   ☐ Cigarettes- _____packs/day ☐ Chew-_____/day ☐ Cigars- _____/day
3. Alcohol: How often? ☐ None ☐ Occasionally ☐ < 3 times/week ☐ > 3 times/week
   How many drinks per week on average? _____
4. Drugs: Do you currently use recreational or street drugs? Y / N
   If yes, please list what type: _____

ADDITIONAL: Is there any other information you would like the providers to know?