NEW PATIENT MEDICAL HISTORY AND MEDICATIONS

ARROYO VISTA
FAMILY MEDICINE

Patient Name:_____ **DOB (Date of Birth):**_____

CURRENT HEALTH HISTORY			
Please list any current diagnosis(es) and/or medical problem(s):			
Diagnosis/Medical Problem	**Date Diagnosed**	**Diagnosis/Medical Problem**	**Date Diagnosed**
1.		**5.**	
2.		**6.**	
3.		**7.**	
4.		**8.**	
When was your most recent complete physical exam?	**Month:**	**Year:**	
What medical or health concern would you like to discuss with the provider at your first visit?:			

SURGICAL HISTORY			
Please list any surgeries (appendix removal, hysterectomy, etc.) you have had below:			
Surgery	**Date of Surgery**	**Surgery**	**Date of Surgery**
1.		**4.**	
2.		**5.**	
3.		**6.**	

ALLERGIES OR UNUSUAL REACTIONS	
Medication(s)	**Reaction**

LIFESTYLE HABITS	
Do you use tobacco? ☐ Yes ☐ No **If yes, what age did you start?:**_____ **Tobacco product(s) do you use?:** _____ **Frequency?:**_____ **Are you a former smoker?** ☐ Yes ☐ No **If yes, start age:**_____ **quit age:**_____ **Do you drink alcohol?** ☐ Yes ☐ No **If yes, how many drinks do you consume per week?:**_____	**Exercise Frequency:** **How many minutes per week do you do cardio?:**_____ **How many minutes per week do you do strength training?:**_____
How many meals do you typically eat out per week?:_____ **How many meals per week are fast food?:**_____	

FAMILY HISTORY

Please indicate any family history of illnesses below where applicable:

FAMILY HISTORY	BIRTH DATE	IF PASSED,		PRESENT CONDITION OR CAUSE OF DEATH
		DATE OF DEATH	AGE AT DEATH	
Mother				
Father				
Other Family:				
Other Family:				
Other Family:				

LIST OF CURRENT MEDICATIONS

Please list **ALL medications you are CURRENTLY taking** (INCLUDING Over-The-Counter (OTC) medications) and **BRING ALL MEDICATIONS** with you including dosage and frequency to your Initial Medical Exam:

Medication	Dose	How Often	Prescribing Clinic or provider

PREFERRED PHARMACY

Please indicate what pharmacies you use and make a note to indicate any special instructions.

Pharmacy Name	Location or Phone Number	Notes

I certify that the information on this form is true and correct to the best of my knowledge.

Signature _____ **Date** _____