Lacamas Medical Group, PC

New Patient
Medical History Form

Name: ______________________
DOB: ________________________

Please list the C**hronic Medical Problems** you are being treated for

1.__________________________________ 4.__________________________________
2.__________________________________ 5.__________________________________
3.__________________________________ 6.__________________________________

List all medications you are currently taking, including over the counter medications

1.__________________________________ 5.__________________________________
2.__________________________________ 6.__________________________________
3.__________________________________ 7.__________________________________
4.__________________________________ 8.__________________________________

List all Allergies to medications and reactions

□ Penicillin □ Sulfa □ IV Contrast/ Shellfish □ Other ______________________

List all Surgeries and Hospitalizations

1.__________________________________ 3.__________________________________
2.__________________________________ 4.__________________________________

Family History

	Diabetes	High Blood Pressure	Heart/Stroke	Asthma	Mental Health	Cancer
Father						
Mother						
Brother						
Sister						
Grandmother (paternal)						
Grandfather (paternal)						
Grandmother (maternal)						
Grandfather (maternal)						

Risk factors/Social History

Do you smoke? □ Yes □ No, If yes How many packs a day? ____________ How many years? ________
Have you quit? □ Yes □ No If yes, when did you quit? _______________
Do chew tabacco? □ Yes □No If yes, how much/how often?_______________
Do you smoke cigars/pipe? □ Yes □ No If yes, how often_______________

Do you use drugs for recreational purposes? □ Yes □No
If yes, check all that apply □ Amphetamines □Cocaine □Marijuana □Other__________________
Have you ever had a problem with prescription pain medications? □ Yes □No

Do you drink alcohol? □Yes □No If yes , how many drinks?_____________ How many a week?________
Have you experienced blackouts due to alcohol? □Yes □No
Have you needed to drink to prevent shakes/sweating? □ Yes □No
Have you ever felt you had a problem with drinking? □ Yes □No

Do you drink Caffine? If so how many a day/week? ___________________

Little interest or pleasure in doing things? □ Yes □ No
Feeling down depressed or hopeless? □ Yes □ No

Do you Exercise? □Yes □No
If yes, How many times a week?_____________________ What type if exercise?_____________________

Seatbelt use? □ Yes □ No (%) □ 100 □ 75 □ 50 □25
Sun exposure: □ Frequently □ occasionaly □ rarely

Do you feel safe inyour relationship? □ Yes □ No
Have you ever been in a relationship where you were threatened , hurt or afraid? □ Yes □ No

Screening Exams

Have you ever had
Colonoscopy □ Yes □ No Flex sigmoidoscopy □ Yes □ No Bone Density Scan □ Yes □ No
If yes, date of last test ____

Females Only
First day of last normal period?_________________
Periods are □ Regular □ Irregular

Last Pap Smear____
History of abnormal paps? □ Yes □ No

Last Mammogram___________________________
Any recent breast pain/lumps/nipple discharge? □ Yes □ No

Total # of pregnancies ________ Live births _______ Miscarriage/abortions_______ Ectopic _______
Are you breastfeeding ? □ Yes □ No
Are you sexually active? □ Yes □ No □ Vasectomy □ Withdrawal (pull out) □ None □ Other __________________
If none, are you desiring a pregnancy at this time?_____________
Currrent Birth control □ Condoms □ Pill □ Nuva Ring □ Nexplanon □ IUD □ Depo □ Tubal

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Review of Systems- In the last 6 months have you experienced any of the following?

General

Fever	☐ Yes	☐ No
Chills	☐ Yes	☐ No
Sweats	☐ Yes	☐ No
Anorexia	☐ Yes	☐ No
Fatigue	☐ Yes	☐ No
Weakness	☐ Yes	☐ No
Discomfort	☐ Yes	☐ No
Weight loss	☐ Yes	☐ No
Sleep disorder	☐ Yes	☐ No

Eyes

Vision loss - 1 eye	☐ Yes	☐ No
Double vision	☐ Yes	☐ No
Eye irritation	☐ Yes	☐ No
Vison loss -both eyes	☐ Yes	☐ No
Blurring	☐ Yes	☐ No
Eye pain	☐ Yes	☐ No
Halos	☐ Yes	☐ No
Discharge	☐ Yes	☐ No
Light sensitivity	☐ Yes	☐ No

Ear/Nose/Throat

Ringing in the ears	☐ Yes	☐ No
Ear discharge	☐ Yes	☐ No
Earache	☐ Yes	☐ No
Decrease hearing	☐ Yes	☐ No
Nasal congestion	☐ Yes	☐ No
Nosebleeds	☐ Yes	☐ No
Difficulty swallowing	☐ Yes	☐ No
Hoarseness	☐ Yes	☐ No
Sore thraot	☐ Yes	☐ No

Respiratory

Cough	☐ Yes	☐ No
Short of breath	☐ Yes	☐ No
Coughing up blood	☐ Yes	☐ No
Chest discomfort	☐ Yes	☐ No
Wheezing	☐ Yes	☐ No
Excessive sputum	☐ Yes	☐ No
Excessive snoring	☐ Yes	☐ No
Sleep disturbance due to breathing	☐ Yes	☐ No

Cardiovascular

Chest pain or discomfort	☐ Yes	☐ No
Palpitations	☐ Yes	☐ No
Fainting/near fainting	☐ Yes	☐ No
Swelling of feet or hands	☐ Yes	☐ No
Difficulty breathing at night	☐ Yes	☐ No
Lightheadedness	☐ Yes	☐ No
Weight gain	☐ Yes	☐ No
Bluish discoloration of lips or nails	☐ Yes	☐ No
Leg cramps with exertion	☐ Yes	☐ No
Short of breath with exertion	☐ Yes	☐ No
Difficulty breathing while laying down	☐ Yes	☐ No
Racing/ skipping heart beats	☐ Yes	☐ No

Gastrointestinal ☐ No

Excessive appetite	☐ Yes	☐ No
Loss of appetite	☐ Yes	☐ No
Indigestion	☐ Yes	☐ No
Vomiting blood	☐ Yes	☐ No
Nausea	☐ Yes	☐ No
Vomiting	☐ Yes	☐ No
Yellowish skin color	☐ Yes	☐ No
Gas	☐ Yes	☐ No
Abdominal pain	☐ Yes	☐ No
Abdominal bloating	☐ Yes	☐ No
Hemorrhoids	☐ Yes	☐ No
Diarrhea	☐ Yes	☐ No
Change in bowel habits	☐ Yes	☐ No
Constipation	☐ Yes	☐ No
Dark tarry stools	☐ Yes	☐ No

Heme/lympahtic

Enlarged lymph nodes	☐ Yes	☐ No
Bleeding	☐ Yes	☐ No
Skin discoloration	☐ Yes	☐ No
Adnormal brusing	☐ Yes	☐ No

Fevers	☐ Yes	☐ No

Genitourinary

Burning with urination	☐ Yes	☐ No
Blood in urine	☐ Yes	☐ No
Discharge	☐ Yes	☐ No
Decrease libido	☐ Yes	☐ No
Erectile dysfunction	☐ Yes	☐ No
Incontinence	☐ Yes	☐ No
Urinary frequency	☐ Yes	☐ No
Urinary hesitancy	☐ Yes	☐ No
Genital sores	☐ Yes	☐ No
Frequent uriantion during the night	☐ Yes	☐ No

Musculoskeletal

Muscle cramps	☐ Yes	☐ No
Joint pain	☐ Yes	☐ No
Joint swelling	☐ Yes	☐ No
Presence of joint fluid	☐ Yes	☐ No
Back pain	☐ Yes	☐ No
Stiffness	☐ Yes	☐ No
Muscle weakness	☐ Yes	☐ No
Arthritits	☐ Yes	☐ No
Gout	☐ Yes	☐ No
Loss of strength	☐ Yes	☐ No
Muscle aches	☐ Yes	☐ No

Dermotology	☐ Yes	☐ No
Rash	☐ Yes	☐ No
Flushing	☐ Yes	☐ No
Change in color of skin	☐ Yes	☐ No
Itching	☐ Yes	☐ No
Skin cancer	☐ Yes	☐ No
Poor wound healing	☐ Yes	☐ No
Dryness	☐ Yes	☐ No
Changes in nail beds	☐ Yes	☐ No
Suspicious lesions	☐ Yes	☐ No
Night sweats	☐ Yes	☐ No
Excessive perspiration	☐ Yes	☐ No
Unusual hair distribution	☐ Yes	☐ No

Neurology

Headaches	☐ Yes	☐ No
Inablility to speak	☐ Yes	☐ No
Seizures	☐ Yes	☐ No
Weakness	☐ Yes	☐ No
Tremors	☐ Yes	☐ No
Memory loss	☐ Yes	☐ No
Brief paralysis	☐ Yes	☐ No
Falling down	☐ Yes	☐ No
Tingling sensation	☐ Yes	☐ No
Poor blanace	☐ Yes	☐ No
Difficulty with concentration	☐ Yes	☐ No
Excessive daytime sleepiness	☐ Yes	☐ No

Psychiatric

Sense of great danger	☐ Yes	☐ No
Anxiety	☐ Yes	☐ No
Thoughts of suicide	☐ Yes	☐ No
Mental problems	☐ Yes	☐ No
Depression	☐ Yes	☐ No
Thoughts of violence	☐ Yes	☐ No
Frightening visions or sounds	☐ Yes	☐ No
Hallucinations	☐ Yes	☐ No
Excessive anger	☐ Yes	☐ No
Insomnia	☐ Yes	☐ No
Panic attacks	☐ Yes	☐ No
Binge eating or induced vomiting	☐ Yes	☐ No
Difficulty with concentration	☐ Yes	☐ No
Crying easily	☐ Yes	☐ No
History of difficulty in school	☐ Yes	☐ No

Endocrine

Excessive hunger	☐ Yes	☐ No
Cold intolerance	☐ Yes	☐ No
Heat intolerance	☐ Yes	☐ No
Excessive urination	☐ Yes	☐ No
Excessive thirst	☐ Yes	☐ No
Weight change	☐ Yes	☐ No

Allergy

Persistent infections	☐ Yes	☐ No
Hives or rash	☐ Yes	☐ No
Seasonal allergies	☐ Yes	☐ No
Food intolerance	☐ Yes	☐ No