PRIORITY HEALTH
FAMILY MEDICINE

NEW PATIENT
MEDICAL HISTORY FORM

Date: _____/_____/_____

Full Name: _____

Date of Birth: _____/_____/_____

Address: _____

City, State, Zip Code: _____

Email Address: _____

Date of Last DOT Exam: _____/_____/_____

Date DOT Certificate Expires: _____/_____/_____

CURRENT MEDICATIONS

MEDICATIONS *(Please list ALL)*	**DOSE** *(Mg., pill, etc.)*	**TIMES PER DAY**

If you need more room to list medications, please write them on a blank sheet of paper with the required information

ALLERGIES o **NO ALLERGIES**

ALLERGY	ALLERGIC REACTION

PERSONAL MEDICAL HISTORY

DISEASE/CONDITION	CURRENT	PAST	COMMENTS
Alcoholism/Drug Abuse			
Asthma			
Cancer *(type:_____)*			
Depression/Anxiety/Bipolar/Suicidal			
Diabetes *(type:_____)*			
Emphysema *(COPD)*			
Heart Disease			
High Blood Pressure *(hypertension)*			
High Cholesterol			
Hypothyroidism/Thyroid Disease			
Kidney Disease			
Migraine Headaches			
Sleep Apnea			
Stroke			
Other:			

Patient Name: _____ DOB: _____

SURGERIES

TYPE *(specify left/right)*	DATE	LOCATION/FACILITY

FAMILY MEDICAL HISTORY

o **NO SIGNIFICANT FAMILY HISTORY IS KNOWN**

CHECK ALL THAT APPLY	Alcohol/DrugAbuse	Asthm	Cancer *type:*____	Emphysema(COPD)	Depression/Anxiet	Bipolar/Suicida	Diabete	EarlyDeath	HeartDisease	HighCholesterol	HighBloodPressure	KidneyDisease	Strok	ThyroidDisease	Migraine	Other:____	Other:____	Other:____
Mother																		
Father																		
Brother																		
Sister																		
Child																		
MGM																		
MGF																		
PGM																		
PGF																		
Other:_____																		

HEALTH MAINTENANCE SCREENING TEST HISTORY

CHOLESTEROL	Date:	Facility/Provider:	Abnormal Result? Y N
HBA1C (3 month sugar test)	Date:	Facility/Provider:	Abnormal Result? Y N

Patient Name: _____ DOB: _____

SOCIAL HISTORY

Occupation *(or prior occupation)*:
Employer:
Marital Status *(check one)*: o Single o Partner o Married o Divorced o Widowed o Other:_____
Do you have children? Y N If yes, how many?

OTHER HEALTH ISSUES

TOBACCO USE	Smoke Cigarettes? Y N *(If you never smoked, please move to Alcohol /Drug Use)*		
Current: Packs/day _____ # of Years _____	***Past:*** Quit Date: _____ Packs/day _____ # of Years _____		
Other Tobacco *(check one)*: o Pipe o Cigar o Snuff o Chew o Vape			
ALCOHOL/DRUG USE	Do you drink alcohol? Y N	o Beer o Wine o Liquor	# of Drinks/week:
Do you use marijuana or recreational drugs? Y N		Have you ever used needles to inject drugs? Y N	
Have you ever taken someone else's drugs? Y N			

EXERCISE	Do you exercise regularly? Y N *(If you answered no, please move to Sleep)*	
What kind of exercise?	***Duration:*** How long (min.): _____ How often: _____	
SLEEP	How many hours, on average, do you sleep at night *(or during the day, if working night shift)*?	
DIET	How would you rate your diet? o Good o Fair o Poor	Would you like advice on your diet? Y N

OTHER PROVIDERS/SPECIALISTS

SPECIALIST	NAME	LAST VISIT
Primary Care Physician- Family Doctor		
Cardiology (Heart Specialist)		
Gastroenterologist (GI)		
OB/GYN		
Neurology (Nerve Specialist)		
Pulmonary (Lung Specialist)		

Patient Name: _____ DOB: _____