CENTENNIAL MEDICAL GROUP

Print Name _____

Date _____ DOB _____

Health History for **NEW** Patients

Your answers on this form will help your health care provide get an accurate history of your medical concerns and conditions. If you are a current patient there is a shorter update form you can use. Please fill in all pages. If you cannot remember specific details, please provide your best guess. If you are uncomfortable with any question, do not answer it. Thank you!

Main reason for today's visit: _____

Other Concerns: _____

Where were you getting your care before? _____

REVIEW OF SYMPTOMS: Please mark the box and/or circle any **persistent** symptoms you have had in the **past few months**. Read through every section and check "no problems" if none of the symptoms apply to you. List other concerns above.

General	**Respiratory**	**Hematologic/Lymphatic**
___ Unexplained weight loss/gain	___ Cough/wheeze	___ Swollen glands
___ Unexplained fatigue/weakness	___ Loud snoring/altered breathing during sleep	___ Easy bruising
___ Fall asleep during day when sitting	___ Short of breath with exertion	___ No problems
___ Fever, chills	___ No problems	**Neurological**
___ No problems	**Gastrointestinal**	___ Headache
Skin	___ Heartburn/reflux/indigestion	___Memory Loss
___ New or change in mole	___ Blood or change in bowel movement	___ Fainting
___ Rash/itching	___ Constipation	___ Dizziness
___ No problems	___ No problems	___ Numbness/tingling
Breast	**Genitourinary**	___ Unsteady gait
___ Breast lump/pain/nipple discharge	___ Leaking urine	___ Frequent falls
___ No problems	___ Blood in urine	___ No problems
Ears/Nose/Throat	___ Nighttime urination or increased frequency	**Allergic/Immune**
___ Nosebleeds, trouble swallowing	___ Discharge: penis or vagina	___ Hay fever/allergies
___ Frequent sore throat, hoarseness	___ Concern with sexual function	___ Frequent infections
___ Hearing loss/ringing in ears	___ No problems	___ No problems
___ No problems	**Musculoskeletal**	**Psychiatric**
Eyes	___ Neck pain	___ Anxiety/stress/irritability
___ Change in vision/eye pain/redness	___ Back pain	___ Sleep problem
___ No problems	___ Muscle/joint paint (where) _____	___ Lack of concentration
Cardiovascular	___ No problems	___ No problems
___ Chest pain/discomfort	**Endocrine**	**Women Only**
___ Palpitations (fast or irregular heartbeat)	___ Heat or cold insensitivity	___ Pre-menstrual symptoms (bloating cramps, irritability)
___ No problems	___ No problems	___ Problem with menstrual periods
		___ Hot flashes/night sweats
		___ No problems

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IMMUNIZATIONS: Check any vaccinations you have had. Add year, if known.
□ Check the box if you don't know the information.

Tetanus (Td) _____ With Pertussis (Tdap) _____ Varicella (Chicken Pox) shot or illness _____

HPV _____ Pneumovax (pneumonia) _____ Influenza (flu shot) _____ Hepatitis A _____

Hepatitis B _____ MMR _____ Meningitis _____ Zostavax (Shingles) _____

Medication	Dose	Times/Day

Medication	Dose	Times/Day

PERSONAL MEDICAL HISTORY: Please indicate whether you have had any of the following medical problems (with approximate date of illness or diagnosis):

___ Alcoholism	___ High cholesterol _____
___ Abnormal Pap smear	___ Hypertension (high blood pressure)
___ Cancer (malignancy)	___ Last Tetanus shot _____
___ Coagulation (bleeding/clotting disorder)	___ Myocardial Infarction (heart attack)
___ Congenital Heart Disease, specify type: _____	___ If you have ever had a blood transfusion, specify date: _____
___ Depression/suicide attempt	___Thyroid problem, specify type: _____
___ Diabetes	___ Other problems _____

SURGICAL HISTORY: Please list all prior operations and dates:

Operation	Date

Operation	Date

ALLERGIES OR REACTIONS (to medication/foods/other agents):

Medication	Reaction or Side Effect

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FAMILY MEDICAL HISTORY: Please indicate with a check (√) family members who have had any of the following conditions:

Medical Condition	Mom	Dad	Sister	Brother	Daughter	Son	Other Close Relatives
Anemia							
Anesthesia Problem							
Asthma							
Bleeding Problem							
Cancer							
Diabetes							
Genetic Diseases							
Hay Fever							
Heart Attack							
High Blood Pressure							
High Cholesterol							
Kidney Diseases							
Stroke							
Thyroid Disorders							
Tuberculosis							

OTHER HEALTH ISSUES:

Tobacco Use

Smoke cigarettes: □ Never □ No □ Yes

(If you never smoked please go to alcohol use question now)

Quit date: _____ How many years did you smoke? _____ Approximately how many packs a day did you smoke? _____

Current smoker: packs/day: _____ # of years: _____ Other tobacco: □ Pipe □ Cigar □ Snuff □ Chew

Alcohol Use

Do you drink alcohol? □ No □ Yes

# of drinks/week: _____ □ Beer □ Wine □ Liquor

Drug Use

Do you use marijuana or recreational drugs? □ No □ Yes

Have you ever used needles to inject drugs? □ No □ Yes

I certify that I have read and understand the above information. To the best of my knowledge, the above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

Signature: _____ **Date**: _____