Aurora Internal Medicine Clinic, PC

New Patient Medical History Form

Name:_____DOB:_____ **Date:**_____

Reason for today's visit:_____

Allergies: _____

Medications & doses: _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

Vitamins/Herbal products?_____

Previous Surgeries: _____

Other Health Problems:

_____

_____

Other Doctors treating you: _____

Family History:

	Father	Mother	Grandparents	Siblings	Children
High Blood Pressure					
Heart Attack					
Stroke					
High Cholesterol					
Blood Clots					
Cancer type?					
Diabetes					
Asthma					
Emphysema					
Kidney Stones					
Ulcers					
Depression					
Other (please list)					

Immunizations dates:
Last tetanus:_____

Last Flu shot:_____

Last Pneumovax:____

Hep A or B_____

Shingles_____

Last physical:_____

Last mammogram:_____

Last PAP:_____

Last colonoscopy:_____

Last Bone density _____

Occupation:_____

Are you under any stress at home/work? _____Describe?_____

_____

Marital status: married single widowed separated divorced x _____ # of children_____

Exercise regimen:_____

Do you use tobacco?_____(cigars chewing tobacco cigarettes) _____packs/day _____# of yrs

Have you ever smoked/chewed? ____ Packs/cans/day ____ # of years smoked/chewed_____Quit date____

Do you drink alcohol? _____ Type?_____How much? _____/day or week

Cups of coffee/day _____ Sodas/day _____ Tea/day_____ Pets_____

Are you pregnant?_____Are you planning a pregnancy? _____Any Tattoos?_____

Have you ever had any blood transfusions?_____Any body piercing besides ears?_____

Illicit street drugs/IV drugs/nasal drugs?_____

Is there anything that hasn't been asked that you would like to tell the doctor?

_____