EraCare Physicians

Internal Medicine - Primary Care

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New Patient Medical History

Please complete this two-sided form prior to your first appointment

Full Name Last, First: _____ Date of Birth: ___/___/ 19___
Age: ____ Sex: ____
How did you hear about our practice? _____

Please state in the box below the reason for your visit

Other Physicians and Specialists
List below your other physicians (i.e., Gyn, Dermatology, GI, Orthopedics, Urology, Psychiatry, etc)

1. Previous PMD: _____ Phone #: _____
2. _____ Phone #: _____
3. _____ Phone #: _____
4. _____ Phone #: _____
5. _____ Phone #: _____
6. _____ Phone #: _____

Preferred Laboratory/ Radiology/ Pharmacy

Preferred Pharmacy	***Address:*** ***phone no.:***
Preferred Lab	
Preferred Imaging:	

Disease Prevention and Health Maintenance

Please list below the most recent dates of your vaccines and health screening tests

	Month/Yr		***Month/Yr***		***Month/Yr***
Flu Vaccine		Mammogram		Eye Exam	
Pneumonia Vaccine		Pap Smear		Heart Catheterization	
Tetanus Vaccine		Colonoscopy		Endoscopy (EGD)	
Hepatitis B Vaccine		Bone Density		Heart Stress Test	
Shingles Vaccine		EKG		Aortic Aneurysm Screen	
Gardasil Vaccine		Chest X-Ray		HIV Test	
Annual Exam					

Medical history

Please list all *CONDITIONS* you either *CURRENTLY HAVE* or *DIAGNOSED WITH IN THE PAST*

Cardiovascular

- ☐ Coronary Artery Disease
- ☐ Heart Attack
- ☐ Congestive Heart Failure
- ☐ Valvular Heart Disease
- ☐ Atrial Fibrillation
- ☐ Hypertension
- ☐ Others ----------

Endocrine/ Metabolic

- ☐ Diabetes
- ☐ High Cholesterol
- ☐ Hypothyroidism
- ☐ Hyperthyroidism
- ☐ Obesity
- ☐ Others ----------

Neurological:

- ☐ Stroke
- ☐ Migraine
- ☐ Parkinsonism
- ☐ Dementia
- ☐ Seizure
- ☐ Others --------

Eye, Ear, Nose and Throat:

- ☐ Cataract
- ☐ Glaucoma
- ☐ Sinusitis
- ☐ Tinnitus
- ☐ Vertigo
- ☐ Others ----------

Auto-Immune diseases:

- ☐ Systemic Lupus
- ☐ Rheumatoid artheritis
- ☐ Inflammatory Bowel Disease (IBD)
- ☐ Others----------

Muscloskeletal

- ☐ Arthritis
- ☐ Gout
- ☐ Others ----------

Respiratory:

- ☐ Sleep Apnea
- ☐ Asthma
- ☐ COPD/Emphysema
- ☐ Bronchitis
- ☐ Tuberculosis
- ☐ Lung Cancer
- ☐ Others ----------

Gastroenterology:

- ☐ Constipation
- ☐ Diarrhea
- ☐ Crohn's Disease
- ☐ Ulcerative Colitis
- ☐ Acid Reflux
- ☐ Pancreatitis
- ☐ Diverticular Disease
- ☐ Bleeding from the Rectum
- ☐ Others ----------

Liver Diseases:

- ☐ Hepatitis A/B/C
- ☐ Liver Cirrhosis
- ☐ Gall stones
- ☐ Others -------

Kidney /Urinary/genital

- ☐ Kidney Stones
- ☐ Kidney failure
- ☐ Dialysis
- ☐ Kidney Cancer
- ☐ Urine Incontinence
- ☐ Others ------

OB/GYN

- ☐ Breast Cancer
- ☐ Polycystic ovarian disease (PCOS)
- ☐ Cervical Cancer
- ☐ Uterine Cancer
- ☐ Infertility
- ☐ Others --------

Hematologic

- ☐ Anemia
- ☐ Leukemia
- ☐ Easy bruising
- ☐ Frequent infections
- ☐ Others ------

Psychological:

- ☐ Anxiety
- ☐ Depression
- ☐ OCD
- ☐ Panic Attacks
- ☐ Schizophrenia
- ☐ Others --------

Skin:

- ☐ Skin rash
- ☐ Persistent itching
- ☐ Acne
- ☐ Other --------

Others:

- ☐ ----------
- ☐ ----------
- ☐ ----------
- ☐ ----------
- ☐ ----------

REVIEW OF SYSTEMS

Please check all *SYMPTOMS* you either *CURRENTLY HAVE* or *RECENTLY EXPERIENCE*

Constitutional:

- ☐ Fever
- ☐ Chills
- ☐ Appetite change
- ☐ Fatigue
- ☐ Weight gain
- ☐ Weight loss
- ☐ Sleep difficulty
- ☐ Others----------

Neurological:

- ☐ Balance problem
- ☐ Headaches
- ☐ Numbness or tingling
- ☐ Confusion
- ☐ Leg or arm weakness
- ☐ Memory loss
- ☐ Paralysis/Weakness
- ☐ Seizure
- ☐ Speech problems
- ☐ Tremors
- ☐ Others ----------

Eye, Ear, Nose and Throat:

- ☐ Blurry vision
- ☐ Double vision
- ☐ bleeding gum
- ☐ Hearing loss
- ☐ Hoarseness of voice
- ☐ Nosebleeding
- ☐ Sinus problems
- ☐ Vertigo
- ☐ Others----------

Cardiovascular

- ☐ Chest pain/Angina
- ☐ Shortness of breath
- ☐ Swelling of the ankles/legs
- ☐ Heart murmur
- ☐ Irregular heartbeat
- ☐ Palpitation
- ☐ Others ----------

Respiratory:

- ☐ Cough
- ☐ Coughing up blood
- ☐ Difficulty breathing
- ☐ Wheezing
- ☐ Others ----------

Gastroenterology:

- ☐ Abdominal pain
- ☐ Acid reflux
- ☐ Change in bowel habits
- ☐ Diarrhea
- ☐ Constipation
- ☐ Flatulence
- ☐ Difficulty swallowing
- ☐ Rectal bleeding
- ☐ Others ----------

Endocrine

- ☐ Excessive thirst
- ☐ Excessive tiredness
- ☐ Too Hot
- ☐ Too cold
- ☐ Others ----------

Skin

- ☐ Skin rash
- ☐ Persistent itching
- ☐ Acne
- ☐ Others ----------

Muscloskeletal

- ☐ Joint pain
- ☐ Joint swelling
- ☐ Back pain
- ☐ Muscle cramps
- ☐ Muscle weakness
- ☐ Others ----------

Urinary/genital

- ☐ Blood in the urine
- ☐ Burning urination
- ☐ Hesitancy
- ☐ Frequent urination at night
- ☐ Unable to intubate the bladder fully
- ☐ Straining to urinate
- ☐ Urgency
- ☐ Urine incontinence
- ☐ Others ----------

OB/GYN

- ☐ Irregular periods
- ☐ Vaginal bleeding
- ☐ Vaginal discharge
- ☐ Others--------

Hematologic

- ☐ Easy bleeding
- ☐ Easy bruising
- ☐ Frequent infections
- ☐ Others --------

Psychological:

- ☐ Anxiety
- ☐ Depressed mood
- ☐ Obsession
- ☐ Panic attacks
- ☐ Others --------

Others:

- ☐ ----------
- ☐ ----------
- ☐ ----------
- ☐ ----------
- ☐ ----------
- ☐ ----------

PAST SURGICAL HISTORY - Please indicate whether and when you have had any of the following surgeries. Use last box in each category to indicate any surgeries not listed.

Cardiovascular

√	Surgery	Approximate Date
	Angioplasty	
	Coronary Artery Bypass Graft (CABG)	
	Pacemaker insertion	
	Stent placement	

General

√	Surgery	Approximate Date
	Brain Surgery	
	Laminectomy	

Gastrointestinal

√	Surgery	Approximate Date
	Appendectomy	
	Bariatric surgery	
	Colon resection	
	Colonoscopy	
	Gall bladder removal (cholecystectomy)	
	Gastric surgery	
	Inguinal hernia repair (groin)	
	Liver transplant	
	Rectal polyp	
	Rectocele repair	
	Umbilical hernia repair (navel)	

Genital/ Urinary

√	Surgery	Approximate Date
	Bladder biopsy (TURBT)	
	Bladder surgery	
	Cystocele repair	
	Cystoscopy	
	Laser lithotripsy/ ESWL	
	Nephrectomy	
	Prostate resection (TURP)	
	Prostatectomy - DaVinci	
	Prostatectomy – laparoscopic	
	Renal transplant	
	Ureteral stent placement	
	Urethral dilation	
	Rectocele repair	
	Prolapse Surgery	
	Urethral Sling	

OB/GYN

√	Surgery	Approximate Date
	Breast surgery	
	Delivery - cesarean	
	Delivery - vaginal	
	Endometrial ablation	
	Hysterectomy (partial)	
	Hysterectomy (total)	
	Lumpectomy of breast	
	Mastectomy	
	Tubal ligation	

Head/ Ears/ Eyes/ Neck/ Throat

√	Surgery	Approximate Date
	Cataract surgery	
	Corneal surgery	
	Deviated septum correction (septoplasty)	
	Eye surgery	
	Sinus surgery	
	Thyroid surgery	

Musculoskeletal

√	Surgery	Approximate Date
	Amputation	
	Back surgery	
	Foot surgery	
	Hand surgery	
	Hip surgery	
	Knee surgery	
	Rotator cuff surgery	
	Shoulder surgery	

Respiratory

√	Surgery	Approximate Date
	Lung surgery	

Skin

√	Surgery	Approximate Date
	Melanoma	

Family History

Blood relatives	Age if Living	Age at death	Major Illnesses (Circle all that applies)
Mother			Heart disease – High blood pressure- Diabetes - Obesity - Stroke - Dementia - COPD- Autoimmune Disease- Alcoholism - Drug Dependence – Cancer (type)---------- Others: ----------
Grandmother			Heart disease – High blood pressure- Diabetes - Obesity - Stroke - Dementia - COPD- Autoimmune Disease- Alcoholism - Drug Dependence – Cancer (type)---------- Others: ----------
Grandfather			Heart disease – High blood pressure- Diabetes - Obesity - Stroke - Dementia - COPD- Autoimmune Disease- Alcoholism - Drug Dependence – Cancer (type)---------- Others: ----------
Father			Heart disease – High blood pressure- Diabetes - Obesity - Stroke - Dementia - COPD- Autoimmune Disease- Alcoholism - Drug Dependence – Cancer (type)---------- Others: ----------
Grandfather			Heart disease – High blood pressure- Diabetes - Obesity - Stroke - Dementia - COPD- Autoimmune Disease- Alcoholism - Drug Dependence – Cancer (type)---------- Others: ----------
Grandmother			Heart disease – High blood pressure- Diabetes - Obesity - Stroke - Dementia - COPD- Autoimmune Disease- Alcoholism - Drug Dependence – Cancer (type)---------- Others: ----------
Brother #			Heart disease – High blood pressure- Diabetes - Obesity - Stroke - Dementia - COPD- Autoimmune Disease- Alcoholism - Drug Dependence – Cancer (type)---------- Others: ----------
Sister #			Heart disease – High blood pressure- Diabetes - Obesity - Stroke - Dementia - COPD- Autoimmune Disease- Alcoholism - Drug Dependence – Cancer (type)---------- Others: ----------
Child #			Heart disease – High blood pressure- Diabetes - Obesity - Stroke - Dementia - COPD- Autoimmune Disease- Alcoholism - Drug Dependence – Cancer (type)---------- Others: ----------

Other blood relatives: _____

_____

SOCIAL HISTORY

Please indicate the following.

Marital Status / Children

____ Single ____ Widowed ____ # of children
____ Married ____ Separated
____ Divorced ____ Other: _____

Alcohol Consumption

____ None ____ Occasional/Social
____ Yes ____ Drinks per week
____ Beers per Week

Current Tobacco Use

____ None ____ Packs per day
____ Yes ____ Cigarettes per day
____ Smokeless Tobacco
____ Other: _____

Previous Smoking History

____ None How long did you smoke? _____
____ Yes How many cigarettes per day on average? ____
When did you stop? _____

Caffeinated Beverages

____ Low
____ Moderate
____ Excessive
____ Cups of coffee per day: _____
____ Other: _____

Recreational Drug Use

____ None
____ Former User, Please Name Substance _____
____ Current User, Please Name Substance _____
____ Other: _____

MEDICATIONS - Please list all current medications & supplements or attach separate list. (Please print)

Start Date	Medication or Supplement Name	Dose	How often	√ if OTC	√ if Rx	List prescribing physician
01/2011	*Uroxatral (Example)*	*10mg*	*Daily*		*√*	*Giesler*

ALLERGIES - Please list all current allergies (Please print)

Medication allergies

Medication	Reaction

Other allergies (foods, latex, iodine, etc.)

Substance	Reaction

/

Patient Signature Date