Welcome to PMG Sunset. Your provider has asked that you fill this NEW PATIENT HISTORY FORM (2 PAGES)

Name ____Date of Birth ___________________________

In addition to establishing care with us at Providence Medical Group, how can we help? **PLEASE TURNOVER FOR PAGE 2**

______**Review prescriptions + chronic problems** (medications often won't be refilled if not reviewed with provider)
______**OR** Have a **Wellness Preventative** visit
______**OR** Discuss **acute new concerns**

Do you need any **medication refilled, referrals, forms completed, or a letter for work**? **Y N N/A**

Screening Questions

If age over 50, have you had a **colonoscopy** in the past 10 years?	**Y**	**N**	**N/A**
If age over 50 + female, have you had a **mammogram** in last 2 years?	**Y**	**N**	**N/A**
If age over 21 + female, have you had a **pap** in the past 3 years?	**Y**	**N**	**N/A**

If age 15 through 50 + female, **Do you plan on becoming pregnant** in the next 1 year **Y N N/A**

For a new problem evaluation: what is the chief symptom and when did it start, are there other associated symptoms?

*____

____

*.____

________ ____

Current Medical problems (Active):

1.____ 4.____

2.____ **5.**____

3.____ 6.____

Current Medications and dose (Active ones. Including "as needed" and supplements)

1.____ 4. ____

2. ____ 5. ____

3. ____ 6. ____

Do you see any specialists now or in the past? What specialty? Who was it? When was the last time you saw them? What do they treat for you? What medications do they prescribe?

1. ____

2. ____

Review of Systems (circle all that apply within the past 2 weeks and are still active)

General: fatigue, fevers
Vision: double vision, worsening vision
Head & Neck: change in hearing, ear pain
Pulmonary: wheezing, shortness of breath
Cardiac: chest pain, rapid heartbeat
Gastrointestinal: nausea or vomiting, black or blood stools
GU: blood in urine, abnormal urinary discharge
Hematology: abnormal bleeding, easy bruising
Neuro: seizures, loss of consciousness
Endocrine: fatigue, high level of thirst
Musculoskeletal: joint swelling , red or hot joints
Mental health: anxiousness, memory problems
Skin & Hair: sores that grow, changing skin moles

PLEASE TURNOVER FOR PAGE 2

Allergies (Please include reaction):

1. ____ 2. ____

Past Medical History:

Past Medical Problems that are now resolved:
What was it / When did it resolve / how did it resolve:

1. ____
2. ____

Hospitalizations (outside of surgeries and pregnancies, not ER visits)
What was it for, what did they diagnosis – year – any complications?

1. ____
2. ____

Surgery History:
Type of surgery , for what? – year?– any complications?

1. ____ 3. ____
2. ____ 4. ____

Family History:
Please list **major family medical problems** that would be worrisome for your own medical risk including mental health. If they have passed away, please list their **cause** of death and **age**?

Mother:____ Sisters: ____

Father:____ Brothers____

Is there any history of **diabetes**? Yes or No Whom?
Is there any family history of **early** cardiovascular disease (heart attack, stroke, mini-stroke) in **males under the age of 55, or females under the age of 65?** Yes or No Whom?
Is there any **family history of cancer**? Yes or No If so, who and what type?

1. ____ 3. ____
2. ____ 4. ____

If you use tobacco or used in the past, when did you start and when did you quit. How many packs or cans did you "average" over that period of time.____

Drug Abuse History (if so, what and when)____

Alcohol Use (how many drinks on **average** in an **average** week):____

Social history: What do you do for a living (describe job responsibility)? If not working now, what did you do in the past?
____

Single / Married / Divorced / Other How many children do you have?________________________________

What level or how many years of total education do you have?_______________________________________

Where were you born?____

Hobbies: 3 things you enjoy doing or have a passion for, or something unique

1.___________________________ 2. ___________________________ 3. ___________________________

For Females: How many times have you been pregnant?________ How many children did you give birth to?_________