NEW PATIENT
MEDICAL HISTORY FORM

MOWERY CLINIC

FULL NAME: _____ DOB: ___ /___ /___ TODAY'S DATE: ___ /___ /___

PERSONAL MEDICAL HISTORY

DISEASE/CONDITION	COMMENTS
☐ Alcoholism/ ☐ Drug abuse	☐ Heart Disease (☐ *CHF,* ☐ *A-Fib,* ☐ *Other:*_____)
☐ Asthma	☐ Headaches / ☐ Migraines
☐ Arthritis	☐ High Blood Pressure
☐ Cancer (*type:* _____)	☐ High Cholesterol
☐ Depression / ☐ Anxiety / ☐ Bipolar Disorder	☐ Renal (*kidney*) Disease
☐ Diabetes	☐ Stroke
☐ Emphysema (*COPD*)	☐ Thyroid Disease (☐ *Hyperthyroidism* ☐ *Hypothyroidism*)
☐ Heart Attack	☐ Other: _____
_____	
_____	

OTHER PROVIDERS/SPECIALISTS

SPECIALIST	NAME/LOCATION	LAST VISIT	SPECIALIST	NAME/LOCATION	LAST VISIT
Cardiology			OB/GYN		
Endocrinology			Pulmonology		
Gastroenterology			Rheumatology		
Nephrology			Urology		
Neurology			Other:_____		

HOSPITALIZTIONS/SURGERIES

TYPE (*specify left or right*)	DATE	DOCTOR/FACILITY
	___ / ___ / ___	
	___ / ___ / ___	
	___ / ___ / ___	
	___ / ___ / ___	
	___ / ___ / ___	
OTHER PREVIOUS ILLNESSES OR INJURIES	**DATE**	**DOCTOR/FACILITY**
	___ / ___ / ___	
	___ / ___ / ___	
	___ / ___ / ___	
	___ / ___ / ___	

WOMEN'S HEALTH HISTORY

Date of last menstrual cycle: ___ / ___ / ___		Age of 1st menstruation:
Total # of pregnancies:	#of live births:	Hysterectomy: ☐ Yes (☐ *total* ☐ *partial*) ☐ No
Pregnancy Complications:		

SOCIAL HISTORY

Occupation:	☐ Retired ☐ Unemployed ☐ Disabled
Employer:	Years of education or highest degree: _____
Marital Status: ☐ Single ☐ Married ☐ Partner ☐ Divorced ☐ Widowed ☐ Other: _____	
Do you have children? ☐ Yes ☐ No	If yes, how many? _____

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MOWERY CLINIC

OTHER

Tobacco Use	Smoke Cigarettes (current or past)? ☐ Yes ☐ No		
Current: Packs/Day: _____ Age started: _____	***Past:*** Packs/Day: _____ Age started: _____ Age quit: _____		
Other tobacco (*check all that apply*): ☐ Pipe ☐ Cigar ☐ Snuff ☐ Chew ☐ Vape (*Device/strength:* _____)			
Alcohol/Drug Use	Do you drink alcohol? ☐ Yes ☐ No	☐ Beer ☐ Wine ☐ Liquor	# of drinks/week: _____
Do you use marijuana or recreational drugs? ☐ Yes ☐ No	Have you used needles to inject drugs? ☐ Yes ☐ No		

FAMILY MEDICAL HISTORY

Do you have a family history of alcohol/drug abuse, asthma, cancer (list type), COPD, depression/anxiety, bipolar disorder, diabetes, heart disease, high blood pressure, kidney disease, stroke, heart attack, headaches/migraines or any other pertinent disorders? If so, please list below.	

MEDICATIONS

Pharmacy name & location: _____

Medication Name	Dose *(mg, #of pills, etc.)*	Times per day

If you need more room to list medications, please list them on a blank piece of paper or on the back of this page with all the required information.

ALLERGIES ☐ No Known Allergies

Allergy	Reaction

HEALTH MAINTENANCE SCREENING TEST HISTORY

Cholesterol	Date: ___ / ___ / ___	Facility/Provider: _____	Abnormal Results? ☐ Yes ☐ No
Colonoscopy or Cologuard	Date: ___ / ___ / ___	Facility/Provider: _____	Abnormal Results? ☐ Yes ☐ No
Mammogram	Date: ___ / ___ / ___	Facility/Provider: _____	Abnormal Results? ☐ Yes ☐ No
Pap Smear	Date: ___ / ___ / ___	Facility/Provider: _____	Abnormal Results? ☐ Yes ☐ No
Bone Density (*DEXA*)	Date: ___ / ___ / ___	Facility/Provider: _____	Abnormal Results? ☐ Yes ☐ No

VACCINATION HISTORY

Last Tetanus booster of TdaP: ___ / ___ / ___	Last Pneumovax/Prevnar (*pneumonia*): ___ / ___ / ___
Last flu vaccine: ___ / ___ / ___	Last Zoster vaccine (*Shingles*): ___ / ___ / ___