NEW PATIENT INFORMATION / Medical History
(Family Physicians of Johnson County)

Name: _____ **Gender**: _____ **DOB**: _____ **Date:** _____

Please list what you would like to discuss today at your appointment:
1) _____
2) _____

PHARMACY:

Local:_____ Mail Order:_____

ALLERGIES:

Allergies to medications with REACTION/S: _____

_____

Allergies to food / environment / other with REACTION/S: _____

MEDICATION LIST:

List ALL Medications you take, including over-the-counter (OTC) medications and vitamins. Include specific doses and when taken. If you don't know, please call your pharmacist to confirm.

NAME of medication	DOSAGE	HOW YOU TAKE IT	INDICATION/WHAT YOU TAKE IT FOR

PERSONAL MEDICAL HISTORY: Please LIST and/or CIRCLE all that apply

1)	7)	13)
2)	8)	14)
3)	9)	15)
4)	10)	16)
5)	11)	17)
6)	12)	18)

ADHD	COPD/Emphysema	Kidney Disease	Rheumatoid Arthritis
Alcoholism	Dementia	High Cholesterol	Seizures
Allergies, seasonal	Depression	HIV	Sleep Apnea
Anemia	Diabetes 1 or 2	Hepatitis	Stroke
Anxiety	Diverticulitis	Irritable Bowel Syndrome	Thyroid Disorder
Arrhythmia (irregular Heart beat)	DVT (blood clot)	Lupus	Ulcerative Colitis
Arthritis	GERD (Acid Reflux)	Liver Disease	
Asthma	Glaucoma	Macular Degeneration	
Bipolar	Heart Disease	Neuropathy	
Bladder Problems/Incontinence	Heart Attack (MI)	Osteopenia/osteoporosis	
Bleeding Problems	Hiatal Hernia	Parkinson's Disease	
Cancer:_____	High Blood pressure	Peripheral Vascular Disease	
Crohns Disease	Kidney Stones	Pulmonary Embolism(PE)	

SURGICAL HISTORY: Please list all prior surgeries and approximate dates performed.

Name of surgery	Date

Health Maintenance / OTHER	Date	Result	Where you had this completed
Colonoscopy		Normal Abnormal	
Mammogram		Normal Abnormal	
Dexa (Bone Density)		Normal Abnormal	
Pap		Normal Abnormal	
Prostate exam		Normal Abnormal	
Last menstrual period	Date: Cycles regular:		
Pregnancies	How many times have you been pregnant: How many deliveries: Miscarriages/Abortions:		

Are there any vision problems that affect your communication? Yes/No

Are there any hearing problems that affect your communication? Yes/No

Are there any limitations to understanding or following instructions

(written or verbal)? Yes/No

SOCIAL HISTORY:

Smoking /Tobacco Use:

Never Current Past Type:_____ Amount/day:_____ # of years_____

Alcohol:

Current Past Never Drinks/week:_____

Substance Abuse:

Current Past Never Type:_____

Occupation: _____

Home/Environment:

Where do you currently reside (home/apartment/residential facility): _____

Who lives with you (significant other, children): _____

Any pets: _____

Diet:

Type of diet: Regular ___, Restricted ___, Diabetic ___, Renal ___, Vegetarian ___,
Other _____

Exercise:

Duration: _____ Times per week: _____ Type of exercise: _____

Sexual history:

Sexually active: ____ Number of current partners: ____
Number of lifetime partners: ____
History of sexually transmitted illnesses: _____

FAMILY HISTORY:

Father: Living/Deceased

Alcoholism Bipolar Depression High Cholesterol Osteopenia/osteoporosis

Anemia Cancer:_____ Diabetes 1 or 2 High Blood pressure Stroke

Asthma COPD/Emphysema DVT (blood clot) Kidney Disease Thyroid Disorder

Arthritis Dementia Heart Disease Migraines

Other:_____

Mother: Living/Deceased

Alcoholism Bipolar Depression High Cholesterol Osteopenia/osteoporosis

Anemia Cancer:_____ Diabetes 1 or 2 High Blood pressure Stroke

Asthma COPD/Emphysema DVT (blood clot) Kidney Disease Thyroid Disorder

Arthritis Dementia Heart Disease Migraines

Other (maternal/paternal aunt or uncle, grandmother or grandfather:_____

_____

Siblings: _____

SPECIALISTS / OTHER PROVIDERS:

List other medical providers you see on a regular basis (i.e. Cardiologist, Pulmonologist, Mental Health Provider, Kidney Doctor, Endocrinologist, OB/GYN, etc) or have seen in the last year:

Name of specialist +/- affiliation with hospital	Indication/what you see them for	Approx date last seen

IMMUNIZATIONS:

To your knowledge, are you up-to-date with your immunizations: Yes / No / Unsure

Please indicate if you have had any of the following vaccines and approximate date:

Influenza vaccine (flu shot): _____

Pneumococcal vaccine (pneumonia shot): _____

Tdap (Tetanus/pertussis shot): _____

Hepatitis A vaccine: _____

Zoster vaccine (shingles shot): _____

Any other immunizations you have had: _____

Childhood vaccines (MMR, Varicella, Hepatitis B, MCV B, MCV ACYW, IPV, Hib, PCV-13, Rotavirus) up-to-date: Yes / No / Unsure

Patient Signature:_____ Date:_____