RIPON FAMILY PHYSICIANS

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New Patient Past Medical History Form

Patient_____ **Birth Date**_____

Your answers on this form will help us understand your medical concerns and conditions better.

Personal Medical History

Please indicate if you have had any of the following problems currently or in the past.

- ☐ Anemia
- ☐ Asthma/Emphysema
- ☐ Cancer/tumors
- ☐ IBS
- ☐ Depression
- ☐ Diverticulosis
- ☐ Diabetes
- ☐ Epilepsy/Seizures
- ☐ Gallstones
- ☐ Gout
- ☐ Heartburn/Acid Reflux
- ☐ Heart Disease
- ☐ High Cholesterol
- ☐ High Blood Pressure
- ☐ Kidney disease/stones
- ☐ Liver disease/Hepatitis
- ☐ Lung disease/pneumonia
- ☐ Pancreatitis
- ☐ Sexually transmitted disease
- ☐ Sleep apnea
- ☐ Stroke
- ☐ Venereal disease/Syphilis
- ☐ Thyroid disease/goiter
- ☐ Tuberculosis
- ☐ Ulcers (stomach or intestinal)

If yes to any of the above, please explain_____

_____

_____

Medication

Please list all your current medications, including medications and supplements not needing a prescription:

Or attach a complete list. ☐ **On No Medications**

Medication	**Dose**	**Directions**	**Taken For:**	**Will our office be refilling?**
_____	_____	_____	_____	☐ Yes ☐ No, refilled by specialist
_____	_____	_____	_____	☐ Yes ☐ No, refilled by specialist
_____	_____	_____	_____	☐ Yes ☐ No, refilled by specialist
_____	_____	_____	_____	☐ Yes ☐ No, refilled by specialist
_____	_____	_____	_____	☐ Yes ☐ No, refilled by specialist
_____	_____	_____	_____	☐ Yes ☐ No, refilled by specialist

Allergies ☐ **No Drug Allergies**

Please list any allergies or reactions to medications:

Medication	Reaction or Side Effect
_____	_____
_____	_____
_____	_____
_____	_____

Surgical History (include type, body part, date): ☐ **No significant surgeries**

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Family History ☐ **Adopted**, family history unknown.

Has anyone in your family (including grandparents, parents, brothers, sisters, or children) had any of the following conditions?

			Family Relationship:		
Bowel/Colon Cancer	☐Yes	☐No	_____	☐Living	☐Deceased at age_____
Breast Cancer	☐Yes	☐No	_____	☐Living	☐Deceased at age_____
Depression	☐Yes	☐No	_____	☐Living	☐Deceased at age_____
Diabetes	☐Yes	☐No	_____	☐Living	☐Deceased at age_____
Heart Disease	☐Yes	☐No	_____	☐Living	☐Deceased at age_____
High Blood Pressure	☐Yes	☐No	_____	☐Living	☐Deceased at age_____
High Cholesterol	☐Yes	☐No	_____	☐Living	☐Deceased at age_____
Kidney Disease	☐Yes	☐No	_____	☐Living	☐Deceased at age_____
Rheumatoid Arthritis	☐Yes	☐No	_____	☐Living	☐Deceased at age_____
Strokes	☐Yes	☐No	_____	☐Living	☐Deceased at age_____
Thyroid Disorder	☐Yes	☐No	_____	☐Living	☐Deceased at age_____
Other_____	☐Yes	☐No	_____	☐Living	☐Deceased at age_____

Personal Habits

Tobacco Use: Cigarettes: ☐Never ☐Former ☐Current Smoker (Packs per day___ # of Years___ Quit-Date___)

Other tobacco: ☐Pipe ☐Cigar ☐Snuff ☐Chew Are you interested in quitting? ☐Yes ☐No

Do you drink alcohol? ☐ Yes, average # of drinks per week___ ☐ No (If no, have you in the past? ☐Yes ☐No

Do you use any recreational drugs, such as marijuana, cocaine, stimulants, narcotics, diet pills? ☐No ☐Yes

(please circle which drugs) Have you ever used needles? ☐Yes ☐No

Are you sexually active? ☐No ☐Not currently ☐Yes – If yes, do you practice safe sex? ☐Yes ☐No

Birth control method_____

Have you ever had any sexually transmitted diseases (STD's)? ☐No ☐Yes_____

Do you exercise regularly? ☐Yes ☐No How many times per week? _____

If yes, what type of exercises?_____

Woman's Health (if applicable)

Total # of pregnancies_____ # of deliveries_____ # of miscarriages_____ # of abortions_____

Age at start of menstrual period _____

Date most recent period began (LMP) _____ Usual length of period _____ days

Have you stopped having menstrual periods? ☐No ☐Yes If yes, when_____

Date of last Pap smear _____ Have you ever had an abnormal Pap smear? ☐No ☐Yes

If yes, give date and describe _____

Do you have regular problems with:

☐ Irregular periods ☐ Bleeding between periods ☐ Hot flashes

☐ Painful periods ☐ Bleeding after menopause ☐ Breast pain/lumps

☐ Heavy periods ☐ Vaginal discharge or itching

If you see a gynecologist for your annual exams, please list their name/phone: _____