

**WEBSTER CITY MEDICAL CLINIC
New Patient History**

WELCOME to the Webster City Medical Clinic. To help us establish you with our practice, please provide us with your medical history. Please be as complete as possible.

Today's date: _____

Name: _____ Date of birth ___/___/___ Age ___
Occupation: _____ Birthplace _____
Marital status: married single divorced widowed
Living arrangement: alone family roommate significant other
Children (list sex/ages): _____
Emergency contact: _____

PAST MEDICAL HISTORY (check all that applies to you)

- | | | |
|--|--|--|
| <input type="checkbox"/> Heart problem | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Diabetes mellitus |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Thyroid problem |
| <input type="checkbox"/> Respiratory problem | <input type="checkbox"/> Stomach problem | <input type="checkbox"/> Other |

PAST SURGERIES/DATE _____

DEVICES YOU USE

- | | | |
|------------------------------------|--|--|
| <input type="checkbox"/> glasses | <input type="checkbox"/> contact lenses | <input type="checkbox"/> hearing aides (R L) |
| <input type="checkbox"/> dentures | <input type="checkbox"/> brace, neck or back | <input type="checkbox"/> IUD, diaphragm |
| <input type="checkbox"/> pacemaker | <input type="checkbox"/> defibrillator | <input type="checkbox"/> artificial limbs |

ALLERGIES: _____

CURRENT MEDICATIONS:

CURRENT HERBS/VITAMINS/SUPPLEMENTS:

FAMILY HISTORY

Father: age _____ (living) age _____ (@ death) Health: _____
Mother: age _____ (living) age _____ (@ death) Health: _____
Brothers/health _____
Sisters/health _____
Children/health _____
Others _____

Name _____

REVIEW OF SYSTEMS

Check any symptoms that currently apply to you:

CONSTITUTIONAL

- poor appetite
- fevers
- chills
- food craving
- weight change
- fatigue

EYES

- blurred vision
- eye pain
- wears corrective lenses
- glaucoma
- poor vision am pm
- other

DIGESTION

- indigestion/heartburn
- belching
- difficulty swallowing
- nausea
- liver trouble
- vomiting
- diarrhea
- cramping bowel
- abdominal gas
- rectal pain/itch
- hemorrhoids
- blood in stools

HEART & CIRCULATION

- chest pain
- lightheadedness
- palpitations
- cold hands/feet
- fainting
- swelling feet
- blood clot history

WOMEN

- pelvic pain
- vaginal discharge
- painful periods
- PMS
- hot flashes
- birth control, Type _____
- itching or soreness

EARS, NOSE, MOUTH THROAT

- headaches
- jaw clicks
- teeth problems
- grinding teeth
- trouble chewing
- facial pain
- sore throat
- mouth sores
- bad breath
- ringing in ears
- nosebleeds
- postnasal drainage
- sinus problem
- trouble with taste
or smell
- poor hearing
- earaches

SKIN, HAIR, BREASTS

- breast lumps or pain
- breast discharge
- rashes
- itching, hives
- hair loss
- dry skin, exzema

IMMUNE SYSTEM

- multiple infections
- allergies to food
- environmental allergies
- other concerns

KIDNEYS/BLADDER

- painful urination
- wake up to urinate
- kidney stone history
- loss of urinary control
- frequent urination
- blood/pus in urine

REPRODUCTIVE

- ___ age periods started
- ___ # pregnancies
- ___ #abortions
- ___ # miscarriages
- ___ # live births
- ___ children living
- ___ age menopause
- past infertility

MUSCLES, BONES, JOINTS

- neck pain
- back pain
- muscle pain
- painful joints: _____
- shoulder elbow
- hip knee ankle
- wrist fingers
- joint swelling
- muscle weakness, cramps

BREATHING & LUNGS

- cough dry irritated
- shortness of breath
- wheezing or asthma
- repeated colds or flu

NEURAL

- seizures
- nerve pain
- poor balance
- poor coordination
- tremors, shaking
- headaches
- numbness

BLOOD SYSTEM

- swollen lymph gland
- anemia
- easy bruising

SEXUAL ORGANS

- sores on genitals
- lumps or swelling
- erection problems
- poor sexual response
- pain with sex
- infertility
- repeated infections

Name _____

SOCIAL HISTORY

Caffeine: _____ c. coffee daily _____ ounces of soda/pop daily
Tobacco: Never _____ packs cigarettes daily for _____ years cigars _____ daily
 _____ cans chewing tobacco per week secondary smoke exposure
Alcohol: Never _____ ounces alcohol per day week recovering alcoholic
Street drugs: Never Used _____ in the past Currently use _____
Name of drug Name of drug

IMMUNIZATIONS

Date of last tetanus shot _____
Date of last pneumonia shot _____
Date of shingles shot _____
Other immunizations _____

DATES OF LAST EXAMS

PAP Smear _____ Mammogram _____ Breast exam by doctor _____
Cholesterol _____ Blood sugar _____ Prostate exam by doctor _____
Rectal exam _____ Colon exam _____

MAIN REASON(S) FOR THIS APPOINTMENT: Rank in terms of importance to you.

1. _____
2. _____

Additional problems or concerns you want addressed:

_____ Please note: we may not be able to address every problem within one visit.

This history record has been designed to facilitate our patients continuity of care at the Webster City Medical Clinic. This is a confidential record and will be kept in strictest confidence at this facility. Information contained here will not be released to anyone without your written authorization to do so.

Date Patient/Guardian signature who filled out this history

Date Provider signature who reviewed this history