Newport Medicine Group

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MEDICAL HISTORY

*NOTE: This information is *confidential* and will not be released without your written permission*

On behalf of my staff and myself, welcome to our office. Providing us with the following information will help us to better serve your medical needs.

Name:_____ Date of Birth_____
Date of Appointment: _____

Please list any specific concerns to be addressed during your visit today:_____
_____
_____
_____

When was your last Physical exam?_____
When was your last Mammogram? _____
When was your last Pap smear?_____
When was your last colonoscopy?_____
When and where was your last blood test? _____

Please list any problems found during your last physical exam or doctors visit:_____
_____
_____

Please list all prescription medications you are currently taking:

Medication Name	Strength/Dosage	Taken how often?

Please list any KNOWN allergies and reactions to medications:_____

Please list any non-prescription medications you use, including pain medications (Aspirin, Tylenol, Advil, etc…),Vitamins and Herbal remedies._____

_____

_____

Do you have, or had any of the following illnesses?

Alcoholism	_____	Hiatal Hernia	_____
Anemia	_____	High Cholesterol	_____
Angina	_____	High blood pressure (hypertension)	_____
Arrhythmia	_____	Hives, Eczema or Hay fever	_____
Arthritis	_____	Joint or Bone Abnormalities	_____
Asthma	_____	Kidney disease	_____
Back Pain/ Injury	_____	Liver Disease	_____
Bleeding disorders	_____	Migraines	_____
Bronchitis	_____	Mononucleosis	_____
Cancer	_____	Pneumonia	_____
Congestive Heart Failure	_____	Prostate Problems	_____
Coronary Artery Disease	_____	Psychiatric Disorders	_____
Depression	_____	Rheumatic fever	_____
Diabetes	_____	Seizures	_____
Diverticulitis/ Diverticulosis	_____	Anxiety or Panic Disorder	_____
Emphysema/ COPD	_____	Substance Abuse	_____
Heart Attack	_____	Tuberculosis	_____
Heart Murmur	_____	Ulcers	_____
Hemorrhoids	_____	Urine/ Bladder Infections	_____
Hepatitis	_____	Urinary Tract Problems	_____
Hernia	_____	Venereal Disease	_____
Whooping Cough	_____	Other (please explain)	_____

_____

Hospitalizations/ Surgeries:

Date:	Reason	Date:	Reason
Date:	Reason	Date:	Reason
Date:	Reason	Date:	Reason

Immunizations:

Immunization	Year	Immunization	Year
Influenza (Flu)		Tetanus	
Pneumonia (Pneumovax)		MMR (Measles, Mumps, Rubella)	
Covid		Shingles(Zostavax or Shingrix)	
Hepatitis A		Hepatitis B	
Varicella (Chickenpox)		Other:	

Family History

Please list any major disease that members of your family have or had—including Heart disease, Stroke, Cancer (include type), Diabetes, High blood pressure, Etc…If the family member is deceased, please list the cause and age of death.

Age and Cause, if deceased

Father:_____

Mother:_____

Brothers:_____

Sisters:_____

Children:_____

Paternal Grandparents:_____

Maternal Grandparents:_____

Personal History

Occupation:_____ Marital Status:_____

List any toxic chemicals you may have been exposed to:_____

Foreign countries visited in the last year:_____

Do you currently smoke (including pipe/cigar/chewing tobacco)?_____

If currently smoking, how much per day and for how long?_____

If you are an ex-smoker, when did you quit?_____

How much did you smoke per day and for how long?_____

If you use alcohol, please estimate how much and how often:_____

Is there any previous history of "heavy" alcohol use?_____

Do you drink Caffeine? How much? (Soda, chocolate, etc...) _____

Is there any current or previous use of Cocaine, Amphetamines, Heroin, Marijuana, PCP, or other addictive drugs?_____

Please describe any exercise that you do. Include type of exercise, how often and for how long:_____

_____

Has there been any recent weight loss or weight gain? _____

Please describe your diet—healthy (low in fat, high in fruits & vegetables), not healthy (high fat/fast foods, etc…), or somewhere in-between:_____

_____

_____