

# 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 \_\_\_\_\_

**Please list any specific concerns to be addressed during your visit today:** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**When was your last Physical exam?** \_\_\_\_\_

**When was your last Mammogram & Pap smear?** \_\_\_\_\_

**When was your last colonoscopy?** \_\_\_\_\_

**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)	_____
Typhoid	_____	Polio	_____
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.

Cause of death

Age of Death

**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? \_\_\_\_\_

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: \_\_\_\_\_

\_\_\_\_\_