Bay Area Medical Clinic

New Patient Form

PATIENT NAME AND DOB	
Name (Last, First, MI):	**DOB:**

CURRENT MEDICAL PROBLEMS *Please list any concerns or problems you would like to address with your physician*

CURRENT MEDICATION LIST

Please list all prescription medications, non-prescription medications, supplements and medical supplies

Medication	Strength	Frequency

ALLERGY HISTORY

Please include allergies to meds and non-meds including foods, iodine, radiology IV dyes and contrast, and latex products

Medication / Non-Medication	Allergic Reaction / Side Effect

PREFERRED PHARMACY

Please check all that apply

☐ Local Pharmacy	☐ Mail Order
Name:	**Name:**
Phone:	**Phone:**

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PAST MEDICAL HISTORY

Please check all past and current medical diagnoses

Cardiology

- ☐ Arrhythmia
- ☐ Atrial Fibrillation
- ☐ Congestive Heart Failure
- ☐ Coronary Artery Disease
- ☐ High Blood Pressure (Hypertension)
- ☐ High Cholesterol (Hyperlipidemia)
- ☐ Heart Attack (MI)
- ☐ Valve Disease
- ☐ Other: _____

Endocrinology

- ☐ Diabetes
- ☐ Hypothyroidism
- ☐ Obesity
- ☐ Other: _____

Gastroenterology

- ☐ Cirrhosis
- ☐ Hepatitis C
- ☐ Acid Reflux (GERD)
- ☐ Irritable Bowel Syndrome
- ☐ Other: _____

Hematology

- ☐ Anemia
- ☐ Blood Clotting in Leg (DVT)
- ☐ Other: _____

Nephrology

- ☐ Chronic Kidney Disease
- ☐ End-Stage Renal Disease
- ☐ Other: _____

Oncology

- ☐ Cancer Type & Location: _____

Ophthalmology

- ☐ Blindness
- ☐ Macular Degeneration
- ☐ Cataracts
- ☐ Glaucoma
- ☐ Detached Retina
- ☐ Diabetic Retinopathy
- ☐ Other: _____

Neurology

- ☐ Alzheimer's Disease
- ☐ Stroke (CVA)
- ☐ Dementia
- ☐ Seizure Disorder
- ☐ Other: _____

Orthopedics

- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Spinal Stenosis
- ☐ Other: _____

Psychiatry

- ☐ Anxiety
- ☐ Depression
- ☐ Bipolar Disorder
- ☐ Other: _____

Pulmonology

- ☐ COPD
- ☐ Chronic Obstructive Asthma
- ☐ Emphysema
- ☐ Obstructive Sleep Apnea
- ☐ Blood Clotting in Lung (Pulmonary Embolism)
- ☐ Other: _____

Rheumatology

- ☐ Rheumatoid Arthritis
- ☐ Other: _____

Other

- ☐ Other: _____
- ☐ Other: _____
- ☐ Other: _____
- ☐ Other: _____

Urology

- ☐ Prostate Cancer
- ☐ Erectile Dysfunction
- ☐ Enlarged Prostate (BPH)
- ☐ Other: _____

Vascular

- ☐ Peripheral Artery Disease
- ☐ Carotid Artery Stenosis
- ☐ Abdominal Aortic Aneurysm
- ☐ Other: _____

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CURRENT AND PREVIOUS DOCTORS			
Previous Primary Care Doctor		**Contact Number**	**Date of Last Visit**
Specialist	**Specialty**	**Contact Number**	**Date of Last Visit**

DIAGNOSTIC / IMAGING / LAB HISTORY					
Type	**Month/Year**	**Provider**	**Type**	**Month/Year**	**Provider**
☐ Eye Exam			☐ Echocardiogram (ECHO)		
☐ Mammogram			☐ EGD		
☐ Colonoscopy			☐ Carotid Doppler		
☐ Fecal Occult Blood Test			☐ Cardiac Stress Test		
☐ Pap Smear			☐ Chest X-Ray		
☐ Bone Density Test (DEXA)			☐ CT of _____		
☐ Prostate Specific Antigen (PSA)			☐ MRI of _____		
☐ Electrocardiogram (EKG)			☐ Other: _____		

IMMUNIZATION HISTORY					
Immunization	**Month/Year**	**Provider**	**Immunization**	**Month/Year**	**Provider**
☐ Influenza			☐ Shingles / Zoster		
☐ Pneumonia			☐ Tetanus		

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SURGICAL HISTORY

Surgery	Month/ Year	Surgery	Month/ Year	Surgery	Month/ Year
☐ CABG		☐ Kidney Removal		☐ Tubal Ligation	
☐ Cardiac Stent		☐ Appendectomy		☐ Cesarean Section	
☐ Pacemaker		☐ Bariatric Surgery		☐ Cataracts	
☐ Valve Replacement		☐ Gallbladder Removal		☐ Glaucoma	
☐ Cervical Fusion		☐ Colon Resection		☐ Skin Cancer Surgery	
☐ Laminectomy		☐ Colostomy		☐ Melanoma	
☐ Total Knee Replacement		☐ Splenectomy		☐ MOHS	
☐ Total Hip Replacement		☐ Lumpectomy (BIL / L / R)		☐ Other: _____	
☐ Carotid Endarterectomy		☐ Mastectomy (BIL / L / R)		☐ Other: _____	
☐ Kidney Stone Removal		☐ Tumor Removal		☐ Other: _____	

HOSPITALIZATION HISTORY

Hospital	Diagnosis	Month/Year

FAMILY HISTORY

Members	Status	Age	Diabetes	Hyper-tension	Heart Disease	Stroke	Mental Illness	Cancer & Type	Unknown
Father	☐ Alive ☐ Deceased		☐	☐	☐	☐	☐	☐ _____	☐
Mother	☐ Alive ☐ Deceased		☐	☐	☐	☐	☐	☐ _____	☐
Siblings	☐ Alive ☐ Deceased		☐	☐	☐	☐	☐	☐ _____	☐

# of Children: _____Sons _____Daughters **Other:** _____

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SOCIAL HISTORY

Tobacco

Smoking Status: ☐ Current smoker ☐ Former smoker ☐ Never smoker **Number of packs per day:** _____

What date did you start smoking? _____ **Total years smoking:** _____

What date did you quit smoking? _____ **Type of tobacco:** _____

Alcohol

Do you drink alcohol? ☐ Yes ☐ No **Number of drinks per day:** _____

Type of alcohol: _____ **Number of drinks per week:** _____

History of alcohol dependence? ☐ Yes ☐ No **Please specify:** _____

Drugs

Do you use drugs? ☐ Yes ☐ No **Type of drugs:** _____

History of drug dependence? ☐ Yes ☐ No **Please specify:** _____

Disability

Are you disabled? ☐ Yes ☐ No **Type and cause:** _____

Occupation

Occupation Status: ☐ Retired ☐ Employed Full-Time ☐ Employed Part-Time ☐ Not Employed

Occupation / Type of Work: _____ **Date Last Worked:** _____

Veteran

Are you a veteran? ☐ Yes ☐ No

ADVANCED DIRECTIVE

I have an advanced directive. Please check all that apply and provide a copy to the office.

☐ Living Will ☐ Durable Power of Attorney for Healthcare Name: _____ ☐ Healthcare Surrogate Name: _____

☐ **I do not have an advanced directive**

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REVIEW OF SYMPTOMS

General
- ☐ Fatigue
- ☐ Fever
- ☐ Weight gain
- ☐ Weight loss

ENT
- ☐ Nasal congestion
- ☐ Post-nasal drip
- ☐ Decreased hearing
- ☐ Ear pain
- ☐ Ringing in the ears
- ☐ Swollen glands

Hematology
- ☐ Breast lump
- ☐ Breast pain
- ☐ Easy bruising
- ☐ Fever
- ☐ Prolonged bleeding
- ☐ Swollen glands
- ☐ Weakness
- ☐ Weight loss

Psychiatric
- ☐ Anxiety
- ☐ Depression
- ☐ Bipolar Disorder
- ☐ Trouble sleeping

Allergy / Immunology
- ☐ Hives
- ☐ Watery eyes
- ☐ Sneezing

Gastrointestinal
- ☐ Abdominal pain
- ☐ Blood in stool
- ☐ Heartburn
- ☐ Nausea / vomiting
- ☐ Change in bowel habits
- ☐ Diarrhea
- ☐ Constipation

Musculoskeletal
- ☐ Carpal tunnel syndrome
- ☐ Painful joint(s)
- ☐ Joint stiffness
- ☐ Low back pain
- ☐ Sciatica
- ☐ Pain in shoulder(s)

Respiratory
- ☐ Cough
- ☐ Hemoptysis
- ☐ Pain with inspiration
- ☐ Shortness of breath
- ☐ Sputum Production
- ☐ Wheezing

Cardiovascular
- ☐ Chest pain at rest
- ☐ Chest pain with exertion
- ☐ Claudication
- ☐ Shortness of breath at rest
- ☐ Shortness of breath with exertion
- ☐ Shortness of breath while laying down
- ☐ Dizziness
- ☐ Fluid accumulation in legs
- ☐ Irregular heartbeat
- ☐ Palpitations

Neurologic
- ☐ Balance difficulty
- ☐ Unsteady gait
- ☐ Headache
- ☐ Memory loss
- ☐ Seizure
- ☐ Tingling numbness
- ☐ Tremors

Men Only
- ☐ Erectile dysfunction

Women Only
- ☐ Vaginal bleeding
- ☐ Pelvic pain
- ☐ Urinary leakage

Endocrine
- ☐ Hair loss
- ☐ Cold intolerance
- ☐ Heat intolerance
- ☐ Irregular menses
- ☐ Weight gain

Genitourinary
- ☐ Blood in urine
- ☐ Difficulty urinating
- ☐ Frequent urination
- ☐ Flank pain

Ophthalmologic
- ☐ Blurred vision
- ☐ Diminished visual acuity
- ☐ Dry eyes
- ☐ Floaters in the eye field
- ☐ Eye pain

Skin
- ☐ Rash
- ☐ Eczema
- ☐ Dry skin
- ☐ Itching
- ☐ Skin lesion
- ☐ Skin spot

Other
- ☐ _____
- ☐ _____

REVIEWED BY

Patient Signature: _____ **Date:** _____

Physician Signature: _____ **Date:** _____