

**NEWTON MEDICAL ASSOCIATES
PATIENT HISTORY**

Date: ___/___/___

Name: _____ Age: _____ DOB: ___/___/___

Marital Status: __ Married __ Single __ Widowed __ Divorced Sex: __ M __ F

Occupation: _____
(if retired, please list pre-retirement profession)

Name of Spouse: _____

Medical History: Please check where appropriate.

Arthritis	yes ___ no ___	Thyroid Disorder	yes ___ no ___
High Blood Pressure	yes ___ no ___	Cholesterol Problems	yes ___ no ___
Diabetes	yes ___ no ___	Heart Failure	yes ___ no ___
Heart Attack	yes ___ no ___	Asthma	yes ___ no ___
Emphysema	yes ___ no ___	Heartburn	yes ___ no ___
Pregnancies	# _____	Last Menstrual Period	_____
Cancer	yes ___ no ___	if yes, please specify	_____
Other	_____		

Surgeries: Please include date and type of surgery. _____

Hospitalizations: Please include date and reason. _____

Do you now or have you ever used tobacco products?
never ___ yes, but quit ___ (date quit and how long used) _____
currently use ___ (how much and for how long) _____

Do you drink alcohol? (beer, wine, hard liquor) no ___ yes ___
if yes, how much? _____

Do you use any illegal drugs? no ___ yes (please specify) _____

Patient Name: _____ DOB: _____

Family History:

Mother: Alive ___ Age ___ Deceased ___ at age ___

Please list any medical problems: _____

Father: Alive ___ Age ___ Deceased ___ at age ___

Please list any medical problems: _____

Siblings or other close relatives: Please list age and any medical problems.

Allergies: Please list type and reaction. _____

Medications: Please list name of medication, dosage and usage. (Include any herbal remedies)

Review of Systems: In the past 3 months have you experienced the following? If yes, please list frequency and nature.

No	Yes	
_____	_____	Difficulty with urination? _____
_____	_____	Fevers? _____
_____	_____	Unintentional weight loss or gain? _____
_____	_____	Weakness? _____
_____	_____	Headaches? _____
_____	_____	Double vision? _____
_____	_____	Blurred vision? _____
_____	_____	Blind spots? _____
_____	_____	Dizziness? _____
_____	_____	Difficulty hearing? _____
_____	_____	Difficulty swallowing liquids? _____
_____	_____	Difficulty swallowing solid food? _____
_____	_____	Chest pain during exertion? _____
_____	_____	Shortness of breath? _____
_____	_____	Abdominal pain? _____
_____	_____	Loss of appetite? _____
_____	_____	Change in bowel movement habits (constipation or diarrhea?) _____
_____	_____	Difficulty walking or circulation problems? _____
_____	_____	Numbness or unexplained pain in the arms and/or legs? _____