Muskegon Family Care

New Patient Medical History Form

Patient Name: _____ **Age:** _____ **Today's Date:** _____

Reason for Visit: _____

Past Medical History: Please check any illnesses/ conditions which YOU have had

___ High Blood Pressure	___ DVT	___ Lung Disease	___ Stroke
___ High Cholesterol	___ Pulmonary Embolus	___ Asthma	___ Diabetes
___ Vein Trouble	___ Tuberculosis	___ Heart Trouble	___ Pneumonia
___ Kidney Disease	___ Nervous Disorder	___ Seasonal Allergies	___ HIV
___ Thyroid Problems	___ Sinus Issues	___ Arthritis	___ Hepatitis
___ Drug Abuse	___ Tonsillitis	___ Gastrointestinal Issues	___ Osteoporosis
___ Alcoholism	___ Bleeding Tendencies	___ Cancer	___ Mood Disorder

Other: _____

History of Serious Injuries / Illnesses? ___ Yes ___ No

If yes, please describe: _____

Medications: Please list any current medications you are taking (including over-the-counter medications)

_____

_____

_____

_____

_____

Are you in need of any **Prescription Refills** today? ___ Yes ___ No

If yes, please specify which medication(s):

_____

Review of Systems Please mark any **persistent** symptoms that you have had in the **past 3 months**

___ Chills	___ Neck Pain	___ Abdominal Pain	___ Joint Pain
___ Fatigue	___ Back Pain	___ Constipation	___ Dizziness
___ Fever	___ Cough	___ Diarrhea	___ Depression
___ New Skin Lesions	___ Shortness of Breath	___ Nausea	___ Anxiety
___ Rash	___ Chest Pain	___ Vomiting	___ Abnormal Bleeding
___ Headaches	___ Swelling	___ Urinary Pain	___ Currently in Pain

Other: _____

Additional Care: Please list any specialty offices that you are seeing (i.e. Cardiology, Behavioral Health, etc.)

_____

_____

_____

_____