Keith Sadel, MD Internal Medicine, LLC

New Patient Medical History Form

Patient Name ______________________ Today's Date __________

Age ____ Birth date ________ Date of last physical examination ________ Referring Physician __________

What is your reason for visit? ______________________________

SYMPTOMS

Check (√) conditions your currently have or have had in the past year

GENERAL
- ☐ Chills
- ☐ Depression
- ☐ Dizziness
- ☐ Fainting
- ☐ Fever
- ☐ Forgetfulness
- ☐ Headache
- ☐ Loss of sleep
- ☐ Loss of weight
- ☐ Nervousness
- ☐ Numbness
- ☐ Sweats

MUSCLE/JOINT/BONE

Pain/ weakness/numbness in:
- ☐ Arms ☐ Hips
- ☐ Back ☐ Legs
- ☐ Feet ☐ Neck
- ☐ Hands ☐ Shoulders

GENITO-URINARY
- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Lack of bladder control
- ☐ Painful urination

GASTROINTESTINAL
- ☐ Appetite poor
- ☐ Bloating
- ☐ Bowel changes
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive hunger
- ☐ Excessive thirst
- ☐ Gas
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Nausea
- ☐ Rectal bleeding
- ☐ Stomach pain
- ☐ Vomiting
- ☐ Vomiting blood

CARDIOVASCULAR
- ☐ Blood Clots
- ☐ Chest pain
- ☐ High blood pressure
- ☐ Irregular heart beat
- ☐ Low blood pressure
- ☐ Murmur
- ☐ Poor circulation
- ☐ Rapid heart beat
- ☐ Swelling of ankles
- ☐ Varicose veins

EYE/EAR/NOSE/THROAT
- ☐ Bleeding gums
- ☐ Blurred vision
- ☐ Crossed eyes
- ☐ Difficulty swallowing
- ☐ Double vision
- ☐ Earache
- ☐ Ear discharge
- ☐ Hay fever
- ☐ Hoarseness
- ☐ Loss of hearing
- ☐ Nosebleeds
- ☐ Persistent cough
- ☐ Ringing ears
- ☐ Sinus problems
- ☐ Vision - Flashes
- ☐ Vision - Halos

SKIN
- ☐ Bruise easily
- ☐ Hives
- ☐ Itching
- ☐ Change in moles
- ☐ Rash
- ☐ Scars
- ☐ Sore that won't heal

MEN only
- ☐ Breast lump
- ☐ Erection difficulties
- ☐ Lump in testicles
- ☐ Penis discharge
- ☐ Sore on penis

WOMEN only
- ☐ Abnormal Pap Smear
- ☐ Bleeding between perio
- ☐ Breast Lump
- ☐ Extreme menstrual pain
- ☐ Hot flashes
- ☐ Nipple discharge
- ☐ Vaginal discharge

Date of last period______
Date of last Pap Smear __________
Have you had a mammogram? ________
Are you pregnant? _____
Number of children ____

CONDITIONS

Check (√) conditions you currently have or have had in the past year.

- ☐ Alcoholism
- ☐ Chemical Dependency
- ☐ Psychiatric Care
- ☐ Anemia
- ☐ Bleeding Disorder
- ☐ Breast Lump
- ☐ Cancer
- ☐ Herpes
- ☐ HIV Positive
- ☐ Multiple Sclerosis
- ☐ Appendicitis
- ☐ Crohn's
- ☐ Hepatitis
- ☐ Hernia
- ☐ Irritable Bowel
- ☐ Ulcerative Colitis
- ☐ Ulcers
- ☐ Arthritis
- ☐ Gout
- ☐ Asthma
- ☐ Bronchitis
- ☐ Emphysema/COPD
- ☐ Pneumonia
- ☐ Tuberculosis
- ☐ Diabetes
- ☐ Goiter
- ☐ Thyroid Problems
- ☐ Heart Disease
- ☐ Heart Attack
- ☐ Congestive Heart Failure
- ☐ High Blood Pressure
- ☐ Blood Clots
- ☐ Pulmonary Embolism
- ☐ Rheumatic Fever
- ☐ Pacemaker
- ☐ High Cholesterol
- ☐ Epilepsy/Seizure disor
- ☐ Migraine Headaches
- ☐ Stroke
- ☐ Kidney Failure
- ☐ Kidney Stones
- ☐ Liver Disease
- ☐ Prostate Problem
- ☐ Cataracts
- ☐ Glaucoma

Medications – List all medications you are currently taking	**Allergies** – List Medications - ONLY

Pharmacy Name	Telephone #	

Family History – Fill in health information about your family

Relation	Age	State of Health	Age at Death	Cause of Death	Check (√) if your blood relatives had any of the following:	Disease	Relationship to you
Father						Arthritis/Gout	
Mother						Aortic Aneurysm	
Brothers						Blood Clots	
						Cancer	
						Chemical/ETOH dependency	
						Diabetes	
						Heart Disease/Stroke	
Sisters						High Blood Pressure	
						Kidney Disease	
						Peripheral Vascular Disease	
						Varicose Veins	
						Other	

Hospitalizations -

Year	Hospital	Reason for Hospitalization and Outcome

Have you ever had a blood Transfusion? ☐ Yes ☐ No
If yes, please give approximate dates

Serious Illness/Injuries	Date	Outcome

Pregnancies -

Year of Birth	Sex of Birth	Complication if any

Health Habits

Check (√) Which substances you use and describe how much you use.

	Substance	
	Caffeine	
	Alcohol	
	Drugs	
	Tobacco Year Quit___	____ How many years ____ Packs per day

Occupational

Check (√) if your work exposes you to the following

	Stress		Hazardous Substances
	Heavy Lifting		Other

Occupation

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature Date

Current Physicians/Specialist Phone number

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Health Maintenance: Please note the approximate date and result of your most recent:

Complete Physical Exam:______________________ Never ○

Eye Examination: ______________________ Never ○

Cholesterol Blood Test: ______________________ Never ○

Dental Examination: ______________________ Never ○

Treadmill Stress Test:______________________ Never ○

Hemoccult Test: ______________________ Never ○

Sigmoidoscopy/Colonoscopy:______________________ Never ○

Bone Density Scan ______________________ Never ○

Women:

PAP Smear ______________________ Never ○

Mammogram ______________________ Never ○

Breast Examination ______________________ Never ○

Men:

Prostate Examination______________________ Never ○

PSA ______________________ Never ○

Immunizations: Give approximate dates of most recent:

Tetanus Vaccine:______________ Pneumonia Vaccine:______________

Hepatitis B:______________ MMR/measles:______________

Chickenpox:______________ Meningococcal:______________

Zostavax:______________ HPV:______________