North Valley Internal Medicine

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New Patient Information

Today's Date: _____

Name: _____ Date of Birth: _____

Age: _____ Sex: ☐ Female ☐ Male

In order to better serve you as a patient, please answer all these questions:

Reason For Visit: _____

_____

Who referred you to us? _____

Past Medical History

(Check if you have any of the following conditions):

- ☐ ASTHMA
- ☐ BRONCHITIS
- ☐ PNEUMONIA
- ☐ TB
- ☐ EMPHYSEMA
- ☐ COPD
- ☐ SCARLET / RHEUMATIC FEVER
- ☐ HEART ATTACK
- ☐ CHF
- ☐ DYSRYTHMIAS
- ☐ HIGH BLOOD PRESSURE
- ☐ BLOOD CLOT
- ☐ ANEMIA
- ☐ YELLOW JAUNDICE
- ☐ BLOOD TRANSFUSIONS
- ☐ LIVER DISEASE
- ☐ DIABETES
- ☐ BLADDER / KIDNEY PROBLEMS
- ☐ POLIO
- ☐ GERMAN MEASLES
- ☐ EPILEPSY OR SEIZURES
- ☐ THYROID DISEASE
- ☐ STOMACH PAIN / ULCERS
- ☐ HEMORRHOIDS
- ☐ DIVERTICULOSIS
- ☐ CROHN'S DISEASE
- ☐ GONORRHEA / SYPHILIS
- ☐ GOUT
- ☐ ARTHRITIS
- ☐ GLAUCOMA
- ☐ CANCER OF: _____
- ☐ RADIATION TREATMENTS
- ☐ OTHER: _____

_____

_____

PAST SURGERIES, HOSPITALIZATIONS, & ACCIDENTS: _____

_____

_____

ALLERGIES: _____

_____

PRESENT MEDICATIONS: _____

_____

Family Medical History

(Check if anyone in your family has any of the following; include parents, grandparents, children, aunts & uncles):

- ☐ TB
- ☐ ASTHMA / ALLERGIES
- ☐ HEART PROBLEMS
- ☐ HIGH BLOOD PRESSURE
- ☐ BLOOD DISORDERS
- ☐ ANEMIA
- ☐ DIABETES
- ☐ KIDNEY DISEASE
- ☐ EPILEPSY
- ☐ GLAUCOMA
- ☐ TWINS / TRIPLETS
- ☐ CANCER OF: _____
- ☐ OTHER: _____

_____

_____

Current Medical Concerns

(Please place a check in the box if you HAVE):

GENERAL

- ☐ Been given a new diagnosis.
- ☐ Engaged in high-risk sexual activity.
- ☐ Had sleeping problems.
- ☐ Had problems with fatigue.
- ☐ Experienced any depression.
- ☐ Had radiation treatments.
- ☐ Found lumps.
- ☐ Lost weight.
- ☐ Gained weight.
- ☐ Had nervousness.
- ☐ Had night sweats.
- ☐ Had fevers.
- ☐ Had chills.

SKIN

- ☐ Had dryness of the skin.
- ☐ Had hair loss.
- ☐ Had changes to the color of your skin.
- ☐ Had changes to a mole or freckle.
- ☐ Use sunscreen.
- ☐ Had a rash.
- ☐ Had irritated or itchy skin.
- ☐ Been diagnosed with anemia.
- ☐ Had bleeding problems.
- ☐ Bruised easily.
- ☐ Had a transfusion.
- ☐ Had memory loss.

EYES

- ☐ Had changes to your vision.
- ☐ Been prescribed new glasses.
- ☐ Had blurry vision.
- ☐ Seen halos around lights.
- ☐ Had double vision.
- ☐ Had eye pain, itching, or drainage.

EYES (cont.)

- ☐ Been diagnosed with glaucoma.
- ☐ Had burning in the eyes.

EARS

- ☐ Had ringing in your ears.
- ☐ Had an earache.
- ☐ Had hearing problems.
- ☐ Had dizzy spells.
- ☐ Heard voices.

NOSE

- ☐ Had nasal or sinus congestion.
- ☐ Had nosebleeds.
- ☐ Had bleeding gums.
- ☐ Had a sore throat.
- ☐ Had enlarged tonsils.
- ☐ Had hoarse voice.
- ☐ Had sores or pain in the ears, nose, mouth, or throat.

LUNGS

- ☐ Had shortness of breath.
- ☐ Had a cough.
- ☐ Coughed up anything.
- ☐ Coughed up blood.
- ☐ Had pneumonia.
- ☐ Had difficulty breathing.
- ☐ Wheezed while breathing

DIGESTIVE

- ☐ Had an increase in your appetite.
- ☐ Had a decrease in your appetite.
- ☐ Had increased thirst.
- ☐ Had nausea.
- ☐ Had vomiting.
- ☐ Had diarrhea.
- ☐ Had constipation.

DIGESTIVE (cont.)

- ☐ Had pain while swallowing.
- ☐ Had difficulty swallowing food, pills, or liquids.
- ☐ Had heartburn.
- ☐ Burped up acid taste.
- ☐ Had changes to your bowel habits.
- ☐ Had cramping in your abdomen.
- ☐ Had bloating.
- ☐ Had a lot of gas / belching.
- ☐ Had black or tar like stools.
- ☐ Found blood in your stools.
- ☐ Had flattening or narrowing of your stools.
- ☐ Had rectal bleeding.
- ☐ Found blood on the toilet seat or in the toilet bowl.

URINARY

- ☐ Had any problems urinating.
- ☐ Increased the amount of times you urinate.
- ☐ Decrease the amount of times you urinate.
- ☐ Lost control or had and leakage of urine.
- ☐ Increased the amount of times you urinate at night.
- ☐ Had an increase in the volume your urine.
- ☐ Had to force urine stream.
- ☐ Had any color changes to your urine.
- ☐ Had sudden urges or difficulty getting to the bathroom soon enough.
- ☐ Had blood in your urine.

CARDIOVASCULAR

- ☐ Had a racing or pounding heartbeat.
- ☐ Had chest pain, heaviness or pressure.
- ☐ Had difficulty breathing while lying down.
- ☐ Had cramping in your arms or legs.
- ☐ Had a heart murmur
- ☐ Had swelling in your legs or feet.
- ☐ Had swelling in your arms or face.

NEUROMUSCULAR

- ☐ Had weakness or inability to move part of your-body.
- ☐ Had numbness or tingling in the
- ☐ arms or legs.
- ☐ Had a seizure.
- ☐ Had tremors or uncontrolled shaking.
- ☐ Had a fainting spell.
- ☐ Had stiffness in the muscles or joints.
- ☐ Had pain in the muscles or joints.
- ☐ Had swelling in the joints.

NEUROMUSCULAR (cont.)

- ☐ Fallen.
- ☐ Had headaches.
- ☐ Had a stroke.

OTHER: _____

_____

_____

MALES ONLY

- ☐ Performed self-testicular exam.
- ☐ Had pain in the testicles.
- ☐ Found lump on the testicles.
- ☐ Had discharge.
- ☐ Had prostate trouble.
- ☐ Had sexual problems.
- ☐ Had straining to urinate.

FEMALES ONLY

- ☐ Performed self-breast exam.
- ☐ Had breast discharge.
- ☐ Found a lump in the breast.
- ☐ Had breast tenderness.
- ☐ Had irregular periods.
- ☐ Had painful periods.
- ☐ Had heavy flow.
- ☐ Had vaginal discharge.
- ☐ Had hot flashes.
- ☐ Had sexual problems.
- ☐ Had an abnormal pap.
- ☐ Become pregnant.
- ☐ Been using the pill and/or IUD

Last Pap Smear: _____

Date of Last Period: _____

Age of 1st Period: _____

Duration in Days: _____

Frequency of Period: _____

# of Live Births: _____

# of Pregnancies: _____

Could you be pregnant now? ☐ Yes ☐ No

Do you use tobacco? ☐ Yes ☐ No

If yes, what type? _____ How much? _____

If yes, have you ever had smoking cessation counseling? ☐ Yes ☐ No

Are you interested in smoking cessation counseling? ☐ Yes ☐ No

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Do you drink alcohol? ☐ Yes ☐ No

If yes, how often? _____

Do you feel you have any problems with alcohol abuse? ☐ Yes ☐ No

Are you interested in counseling for alcohol abuse? ☐ Yes ☐ No

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Do you use any illicit drugs? ☐ Yes ☐ No If yes, what: _____

Are you interested in counseling for drug abuse? ☐ Yes ☐ No

Are you up to date on your current vaccines / immunizations? ☐ Yes ☐ No

Have you obtained a flu / pneumonia vaccine at an outside facility? ☐ Yes ☐ No

If yes, when and where? _____

If you are not up to date or unsure, would you like us to assist you in becoming current with your vaccines / immunizations? ☐ Yes ☐ No

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If you are a diabetic, have you:

- Been to a podiatrist in the last 12 months? ☐ Yes ☐ No
- Been to an ophthalmologist in the last 12 months? ☐ Yes ☐ No
- Attended a diabetic education class at our office in the last 12 months? ☐ Yes ☐ No
- If no, are you interested in receiving more information about our class? ☐ Yes ☐ No

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Do you currently see any specialists that you we need to be informed of?

Name Specialty Phone Number

_____

_____

Have you had any recent ER / Urgent Care visits we do not know about?

Date: Reason / Diagnosis

_____

_____

Your current medications, prescription and over the counter, as well as any vitamins or supplements will be reviewed with you by a Medical Assistant. Please know the name of medication, amount, when and how often you take each medication. If you do not know this information today please call back and provide us with your medication details.

I have answered all of these questions to the best of my ability

Signature: _____ Date: _____

Print Name: _____