CORONADO INTERNAL MEDICINE, P.C.

New Patient Health History

Name (Last, First, Middle) _____ Date of birth _____ Age ___

Address: _____

Home phone: _____ Cell phone: _____ Work phone: _____

Occupation: _____ Insurance carrier: _____

Please list all ALLERGIES to medications and your reaction to that medication:

I am allergic to the following medication(s):	Reaction

Please list all medications you are currently taking. Be sure to include PRESCRIPTION medications and OVER-THE-COUNTER medications, such as aspirin, multi-vitamins, etc.

Medication	For what condition?	How much do you take?	How often do you take it?

VACCINATION HISTORY. Please indicate the year of your last vaccination. If you have never received a particular vaccination, write "NA", for "not applicable."

Tetanus _____ Flu _____ Pneumonia _____

PERSONAL MEDICAL HISTORY. Please check all conditions which you currently have or have had in the past.

AIDS or HIV positive		Kidney disease	
Alcoholism		Kidney stones	
Anemia		Liver disease	
Anorexia/Eating disorder		Measles	
Anxiety/Panic disorder		Mental illness	
Appendicitis or Appendectomy		Migraine headaches	
Arthritis		Multiple sclerosis	
Asthma		Mumps	
Bleeding disorder		Osteoporosis	
Blindness		Pacemaker	
Breast lump (benign)		Pain (chronic)	
Chronic bronchitis		Pneumonia	
Cancer (please write what type)		Polio	
		Prostate problems	
Cataracts		Rheumatic fever	
Chicken pox		Rubella (German measles)	
Colon polyps		Scarlet Fever	
Deafness or Hearing loss		Seizures	
Depression		Sexual problems (erectile dysfunction, decreased interest, etc.)	
Diabetes		Sexually transmitted disease (such as syphilis, Chlamydia, etc.)	
Drug abuse/dependency		Skin disease	
Emphysema/COPD		Stomach ulcer/intestinal bleeding	
Fibromyalgia		Stroke	
Food allergies (eggs, peanuts, etc)		Suicide attempt	
Gout		Thyroid problems	
Hay fever		Tuberculosis (TB)	
Heart disease		Valley Fever (Cocci)	
Heart murmur		Other (please explain)	
Hepatitis (A, B, or C)			
Herpes			
High cholesterol			
High blood pressure			

Please list all HOSPITALIZATIONS AND SURGERIES within the past five years, the approximate dates and hospital name, and the reason for the hospitalization or surgery.

Date and Place	Reason

FAMILY MEDICAL HISTORY. Please check whether a family member currently has or had any of the following conditions:

	Father	Mother	Children	Brother(s) or Sister(s)	Father's Parents	Mother's Parents
Alcoholism	☐	☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐	☐
Bleeding disorder	☐	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐
Epilepsy or convulsions	☐	☐	☐	☐	☐	☐
Glaucoma	☐	☐	☐	☐	☐	☐
Heart disease	☐	☐	☐	☐	☐	☐
High blood pressure	☐	☐	☐	☐	☐	☐
Kidney disease	☐	☐	☐	☐	☐	☐
Mental illness	☐	☐	☐	☐	☐	☐
Migraine headaches	☐	☐	☐	☐	☐	☐
Osteoporosis	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐
Thyroid disease	☐	☐	☐	☐	☐	☐

Have you ever been advised to have an operation which you did <u>not</u> have? If YES, please explain. ☐ YES ☐ NO

Have you ever had a blood transfusion? ☐ YES ☐ NO

Have you ever been refused as a blood donor? ☐ YES ☐ NO

Have you ever applied for medical or life insurance and been denied? ☐ YES ☐ NO

LIFESTYLE HABITS. Please answer the following questions.

Have you ever used tobacco products? If you currently use tobacco products, how much do you use and for how long have you been doing so? If you no longer use tobacco products, when did you quit and how much did you use?	☐ YES	☐ NO
Do you consume alcohol? If yes, about how many drinks per week?	☐ YES	☐ NO
Do you consume caffeine? If yes, about how many drinks per week?	☐ YES	☐ NO
Do you exercise **routinely**? If yes, what type of exercise, and how often?	☐ YES	☐ NO
Do you **always** wear a seatbelt when riding in a car?	☐ YES	☐ NO
Do you receive routine dental care?	☐ YES	☐ NO
Are you satisfied with your sleep habits?	☐ YES	☐ NO
Do you have smoke detectors in your residence? If yes, do you check them yearly?	☐ YES ☐ YES	☐ NO ☐ NO
Do you have fire extinguishers in your residence?	☐ YES	☐ NO
Do you have a carbon monoxide detector in your residence?	☐ YES	☐ NO
Do you have a living will or Medical Power of Attorney? If you do not, are you interested in receiving information about living wills?	☐ YES ☐ YES	☐ NO ☐ NO

FOR WOMEN ONLY: PLEASE ANSWER THE FOLLOWING QUESTIONS			
Are you currently pregnant?	☐ YES	☐ NO	
Are you planning to become pregnant?	☐ YES	☐ NO	
How many times have you been pregnant? _____			
How many of those pregnancies resulted in live births? _____			
Do you still have menstrual periods?	☐ YES	☐ NO	
If yes, which of the following describes your menstrual flow:	☐ Regular	☐ Irregular	☐ Pain/Cramps
What is the usual number of days your period lasts? _____			
What is the usual number of days between periods? _____			
What was the first day of your last period? _____			
Do you currently use birth control? If yes, what type?	☐ YES	☐ NO	
Do you ever experience pain or bleeding during or after sex?	☐ YES	☐ NO	
What was the approximate date of your last Pap Smear? _____			
Was the result:	☐ Normal	☐ Abnormal	
What was the approximate date of your last mammogram? _____			
Was the result:	☐ Normal	☐ Abnormal	

Thank you for taking the time to complete this important health questionnaire. Please sign and date below.

_____ _____

Signature **Date**

REVIEWED by PHYSICIAN: _____

FOR MEN ONLY: PLEASE ANSWER THE FOLLOWING QUESTIONS		
Have you ever had a rectal/prostate exam? ☐ No ☐ Yes If yes, when?		
In the past 3 months, have you had:		
Pain or lump in testicles	☐ Yes	☐ No
Weak or slow stream of urine	☐ Yes	☐ No
Difficulty with erection	☐ Yes	☐ No
Discharge from penis	☐ Yes	☐ No
Sexually transmitted disease	☐ Yes	☐ No
Other (please describe)		
Do you perform regular testicular self-examination? ☐ Yes ☐ No		
Have you ever had any male surgery? ☐ Yes ☐ No		
Are you satisfied with your sexual relationships? ☐ Yes ☐ No		
Do you have any problems or questions about sex that you would like to discuss with your doctor? ☐ Yes ☐ No		

Thank you for taking the time to complete this important health questionnaire. Please sign and date below.

_____ _____

Signature **Date**

REVIEWED by PHYSICIAN: _____