

Name: _____

Date Completed: _____

**East Side Medical Practice, P. C.
New Patient Information Form**

Welcome to East Side Medical Practice! Please complete this history form and either send it via email or bring it with you to your upcoming office visit.

PAST MEDICAL HISTORY:

Do you have or have you ever been diagnosed with one of the following conditions: None

High Blood Pressure

Seasonal Allergies

High Cholesterol

Asthma

Diabetes

Gastric Reflux

Heart Attack or Stroke

Hypothyroidism

Cancer (type): _____

Other: _____

SURGICAL HISTORY:

Have you ever had surgery? None or Please list surgery type and year:

FAMILY HISTORY

Father: Heart Disease Diabetes Blood Pressure Cholesterol Asthma Cancer _____

Mother: Breast Cancer Uterine Cancer Diabetes Blood Pressure Cholesterol _____

Siblings: None Diseases in Siblings: _____

Others in extended family: None Diseases _____

MEDICATIONS:

Please list the medication name, dose strength and frequency you take it. Please include any over the counter supplements: None

1. _____

2. _____

3. _____

4. _____

ALLERGIES:

No known drug allergies No environmental allergies No known food allergies No allergy to shellfish/iodine

I have these allergies: _____

Name: _____

Date Completed: _____

SOCIAL:

Non Smoker Former Smoker Quit (when: _____) Current Some Days Current every day How much: _____ packs per day)

Alcohol use : Social Rarely Non-Drinker Too much Recovering

Exercise: Daily Regular Occasional Rarely or Never

Married Single Engaged Partnered Same Sex Partner Separated Divorced Widowed

Employed: _____ Home maker Retired Student

Children: _____

Diet: Excellent Good Fair Poor

HEALTH CARE SCREENINGS:

Have you ever had one of the following screening procedures? If so when:

None Colonoscopy Endoscopy Bone Density Scan Mammogram Other: _____

VACCINATIONS:

Have you ever had the following vaccinations? If so, when

Don't remember Hepatitis A Hepatitis B Flu Shot Pneumonia Shingles
 Tetanus Diphtheria Pertussis Booster

WOMEN ONLY:

When was the first day of your last menstrual cycle? Date: _____
When was your last Pap Smear? Date: _____
When was your last mammogram? Never or Date: _____
 Pregnancies: _____

PHARMACY INFORMATION:

(Just for your chart, we won't use it unless you tell us and you can have more than one)
Please list the best pharmacy to have your prescriptions sent electronically:

Pharmacy Name: _____
Phone Number: _____
Zip Code: _____
Address: _____

Does your insurance have a mail-away pharmacy option for daily medications? If so, which mail away pharmacy do you use (located on your insurance card): _____

Thanks!