Name: _____ Date Completed: _____

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

Welcome to East Side Medical Practice! Please complete this history from 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
❑High Cholesterol
❑Diabetes
❑Heart Attack or Stroke
❑Cancer (type): _____
❑Seasonal Allergies
❑Asthma
❑Gastric Reflux
❑Hypothyroidism
❑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!