

Name: \_\_\_\_\_

Date form completed: \_\_\_\_\_

Birth Date: \_\_\_\_\_

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

**Welcome** to East Side Medical Practice! Please complete this history form and send it via email **info@eastsidemedicalpractice.com** or bring a copy 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

Lung disease

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  Colon Cancer  \_\_\_\_\_

Mother:  Breast Cancer  Diabetes  Blood Pressure  Cholesterol  Colon Cancer  \_\_\_\_\_

Siblings:  No Siblings Diseases in Siblings: \_\_\_\_\_

Others in extended family:  UNK 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: \_\_\_\_\_

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**SOCIAL:**

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

Alcohol use :  Social (Ave. drinks/week) \_\_\_\_\_  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 (listed on your insurance card):  OptumRx  ExpressScripts  
 CVS Caremark  Cigna Home  Future Scripts  Aetna Home  Other: \_\_\_\_\_