OhioHealth

MRN (office use only):_____

New Patient History Form (Adult)

New Patients, please take a moment to fill out both pages and complete all areas to the best of your knowledge. In doing so we will have a better understanding of you and target any concerns/issues you may have. **Existing Patients** please fill out both pages and complete all areas to the best of your knowledge. This will allow us to review your medical history and updates changes that may have occurred over the past year.

Name: _____ Date of Birth: _____ Date: _____

Marital Status: _____ Name of Spouse or Significant Other: _____

Children (include age): _____

Education: _____Profession:_____

Do you currently have a living will? **Y N** Do you have a power of attorney? **Y N**

MEDICATIONS: Please list all medications you are currently taking and include dose and frequency, including over the counter and herbal supplements.

1.	6.
2.	7.
3.	7.
4.	9.
5.	10.

PAST MEDICAL HISTORY: Please list all medical conditions for which you have been treated in the past

1.	6.
2.	7.
3.	8.
4.	9.
5.	10.

ALLERGIES: Please list all medications you are allergic to and the allergic reaction that occurs.

Please check box if you are allergic to latex: □ **Please check box if you have no known allergies: □**

1.	3.
2.	4.

IMMUNIZATIONS: Please date your most recent immunization

Hepatitis A_____	Flu Shot_____	Tetanus_____	Shingles_____
Hepatitis B_____	Chicken Pox_____	Meningitis_____	
HPV_____	Pneumonia_____	MMR_____	Other_____

PAST SURGICAL HISTORY: Please list all operations and dates

1.	4.
2.	5.
3.	6.

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Name: _____ Date of Birth: _____

FAMILY HISTORY: Please list every family members age (or age at death) and any illnesses: cancer, diabetes, heart disease, high blood pressure, lung problems, kidney problems, depression, arthritis, and allergies

Mother:	**Father:**
Maternal Grandfather:	**Maternal Grandmother:**
Paternal Grandfather:	**Paternal Grandmother:**
Siblings:	**Children:**

WOMEN:
Number of pregnancies_____ Children_____ Miscarriages_____ Abortions_____

Last pap smear_____ Have you had an abnormal pap? **Y N** Last period_____ Age at Menopause_____

Age at first period_____ Last bone density scan_____ Last Mammogram_____

MEN:
Last prostate exam_____ Last prostate blood test (PSA) _____

BOTH:
Last colonoscopy / sigmoidoscopy_____

SYSTEM REVIEW: Please mark the box if you have experienced any of the following symptoms within the last 6 months.

GENERAL:
Fever___
Chills___
Headaches___
Night Sweats___
Appetite Change___
Unexplained Weight Loss/gain___
Fatigue___

EYES:
Eye pain with sunlight___
Vision change___
Redness___
Discharge___
Pain___
Itching___
Glasses___
Glaucoma___

EARS/NOSE/THROAT:
Hearing loss___ Ringing in ear__
Nosebleeds___ Runny nose___
Nasal congestion___ Earache__
Post nasal drip___ Sore throat___
Mouth sours___ Dentures___

HEART:
Palpitations___ Leg swelling___
Passing out___ Leg pain while walking___
Chest pain___
Difficulty breathing at night___

LUNGS:
Cough___
Coughing blood___
Shortness of breath___
Wheezing___
Coughing up phlegm___

STOMACH/INTESTINES:
Belly pain___ Nausea___
Vomiting___ Diarrhea___
Constipation___ Bloody stool___
Dark stool___ Heartburn___
Trouble breathing___

URINARY TRACT:
Pain w/ urination___
Blood in urine___
Sudden urges to urinate___
Urinating more frequently___
Incontinence___
Decrease stream___

WOMEN:
Vaginal itching___
Vaginal discharge___
Abdominal vaginal bleeding___

MEN:
Testicular pain___
Testicular mass/swelling___
Penile discharge___
Erectile dysfunction___

BREAST:
Pain__ Lumps___ Discharge___ Implants___

MUSCULASKELTAL:
Joint pain___ Stiffness___ Weakness___
Joint swelling___ Back pain___
Muscle pain___ Muscle cramps___

SKIN
Itching___ Redness___ Rash___ Hair loss___
Nail change___ Moles___ Dry skin___

NEUROLOGIC:
Memory loss___ Numbness___
Problems walking___ Problems speaking___
Dizziness___ Tremor___

PSYCHIATRIC:
Depression___ Suicidal thoughts___
Homicidal thoughts___ Hallucinations___
Mood changes___ Anxiety___
Sleep disturbance___

ENDOCRINE:
Heat/cool intol__ Hair changes___
Increased urination___ Increased thirst___

HEMATOLOGY:
Anemia___ Easy bruising___
Bleeding of skin/gums___ Swollen glands___

ALLERGY/IMMUNE SYSTEM:
Frequent infections___
Breathing difficulties/exposed to allergens___
Environmental allergies___

Do you exercise regularly? **Y N** _____

Do you drink alcohol? **Y N** If yes, how many per day? _____ How many per week? _____

Do you currently smoke or have you smoked in the past? If yes, how much? _____For how long? _____

Thank you for taking time to fill out the forms. Please sign and date:

Patient Signature_____ Date: _____

Physician Signature_____ Date: _____