Aultman Medical Group

New Patient History

Patient name	***Date of birth***	***Age***
Family physician:		

ALLERGIES	**MEDICATION ALLERGIES**
Do you have an allergy to Latex? □ Yes □ No	*Medicine(s)*
Do you have allergies to food? □ Yes □ No	*Reaction (s)*
	Medicine(s)
	Reaction (s)
CAFFIENE USE ____ PER DAY ____ PER WEEK	**NICOTINE USE ____ PER ____ DAY/WEEK**
ALCOHOL USE ___ YES ___NO (if yes see below) **____ Drinks/Day or ____ Week for past ____ years**	**PAST OR PRESENT DRUG USE___ YES ___NO (If yes see below)** **List Type & Frequency _____**

MEDICATION LIST

Date	Medication Name Prescription and Herbal or Over the Counter	Dose	Frequency	Route	Reason	Ordering Physician

Aultman Medical Group

Behavioral Health and Counseling Center

Name of Individual/Maiden/AKA (Last, First, MI)	*Date of Birth*	*Today's Date*

PAST ILLNESSES OF YOURSELF AND FAMILY

You	Family		You	Family		You	Family	
□	□	Alcoholism	□	□	High Blood Pressure	□	□	Stroke
□	□	Anemia	□	□	Kidney Disease	□	□	Suicide Attempt
□	□	Asthma	□	□	Liver Disease	□	□	Thyroid Disease
□	□	Cancer/Tumor	□	□	Hepatitis	□	□	Tuberculosis, TB
□	□	Diabetes	□	□	Lung Disease	□	□	Ulcer in GI Tract
□	□	Drug Abuse	□	□	Mental Illness	□	□	Venereal Disease (STD)
□	□	Depression	□	□	Osteoarthritis	□	□	High Cholesterol
□	□	Epilepsy/Seizures	□	□	Osteoporosis	□	□	HIV/Immune DX
□	□	Glaucoma	□	□	Phlebitis	□	□	Contagious Disease _____
□	□	Heart Disease	□	□	Rheumatic Arthritis	□	□	Other:

PAST SURGICAL HISTORY

DATE	**SURGERY TYPE**

REVIEW OF SYSTEMS (Please check each item "yes" or "no" as they relate to your health)

CONSTITUTIONAL	YES	NO	**RESPIRATORY**	YES	NO	**HEMATOLOGY/LYMPH**	YES	NO
Weight Loss			Cough			Easy Bruising/Blood Disorder		
Fatigue			Coughing Blood			Gums Bleed Easily		
Fever			Chills			Enlarged Glands		
EYES			Wheezing			**MUSCULOSKELETAL**		
Glasses/Contacts			**GASTROINTESTINAL**			Joint Pain/Swelling		
Eye Pain			Heartburn/Reflux			Stiffness		
Double Vision			Nausea/Vomiting			Muscle Pain		
Cataracts			Constipation			Back Pain		
EARS, NOSE, THROAT			Change in BM's			**SKIN**		
Difficulty Hearing			Diarrhea			Rash/Sores		
Ringing in Ears			Jaundice			Lesions		
Vertigo			Abdominal pain			Itching/Burning		
Sinus Trouble			Black or Blood BM			**NEUROLOGICAL**		
Nasal Stuffiness			**GENITOURINARY**			Loss of Strength		
Frequent Sore Throat			Burning/Frequency			Numbness		
CARDIOVASCULAR			Nighttime			Headaches		
Murmur			Blood in Urine			Tremors		
Chest Pain			Erectile Dysfunction			Memory Loss		
Palpitations			Abnormal Discharge			**FEMALES ONLY**		
Dizziness			Bladder Leakage			Date Last Mammogram		
Fainting Spells			**ALLERGIC/IMMUNOLOGIC**			Normal _____ Abnormal _____		
Shortness of Breath			Hives/Eczema			Age Onset Periods:		
Difficulty lying flat			Hay Fever			Age Onset Menopause:		
Swelling Ankles			**PSYCHIATRIC**			Periods Regular? Yes____ No ___		
ENDOCRINE			Anxiety/Depression			Number Pregnancies: _____		
Loss of Hair			Mood Swings			**Birth Control** Current Use ___Yes ____No		
Heat/Cold Intolerance			Difficulty Sleeping					

SIGNATURE/REVIEWING PROVIDER _____

PATIENT SIGNATURE / Date: _____