ACE HEALTH AND WELLNESS CENTER PLLC

Internal Medicine Clinic "Your health is our priority"

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New Patient Medical History - Please complete this two-sided form prior to your first appointment

Name: _____ Date of Birth: ____/____/____Age: _____Sex: M_ / F_

♦ Past Medical History ♦			
Condition / Disease ***Year Began***		***Condition / Disease***	***Year Began***
❑ Hypertension		Other(s):	
❑ High Cholesterol			
❑ Hypothyroidism (low thyroid)			
❑ COPD, Emphysema or Asthma			
❑ Diabetes			
❑ GERD			
❑ Depression or Anxiety			
❑ Heart Problems -			

♦ Past Surgical Procedures ♦			
Operation:	***Month / Yr***	***Operation:***	***Month / Yr***

♦ Medication Allergies or Intolerances ♦			
List below medications causing an allergic reaction (i.e., rash, swelling) or intolerance (i.e., nausea)			
Medication	***Reaction***	***Medication***	***Reaction***

♦ Medications, Vitamins and Herbal Supplements ♦					
Medication	***Strength***	***Number of pills taken & frequency***	***Medication***	***Strength***	***Number of pills taken & frequency***
Example: *Tylenol*	*500 mg*	*1 - twice daily*			

♦ Social, Educational and Work History ♦

Marital Status: Work Status (circle one): Employed Unemployed / Retired / Disabled	Children? Yes / No Boys: Girls: Current or Prior Occupation:

What type of exercises, if any do you perform, duration & frequency?

In what type of residence do you live (i.e., house, assisted living, nursing home)?

Do you drink alcohol? Yes / No No. of drinks per week?

Are you a current smoker?	If you smoke, how many packs per day?	
Are you a former smoker?	If so, what year did you quit?	No. of years you smoked?

On average, how much did you smoke per day?

Are you sexually active: Yes / No | Do you have sex with: Men / Women / Both

Do you have a Medical Power of Attorney? Yes / No

If Yes who? POA Phone #: ( )

Do you have a living will? Yes / No

♦ Family Health History ♦

Please list below the health history of your blood (genetic) first degree relatives

Relative	***Living or Deceased***	***Current age or age at death***	***Cause of Death***	***Health Problems***
Father:				
Mother:				
Brother(s):				
Sister(s):				

♦ Review of Systems ♦

Please review the following symptoms and circle those items that are a problem for you

Vision problems	Wheezing	Lumps in breast	Frequent Urination	Excessive hunger
Hearing problems	Asthma / COPD	Breast discharge	Incontinence	Excessive thirst
Sinus trouble	Emphysema	Trouble swallowing	Blood in Urine	Weakness
Hay fever	Bronchitis	Nausea	History of STD's	Fatigue
Nosebleeds	TB exposure	Vomiting	Anemia	Fever / Sweating
Sore throat	Chest pain	Abdominal pain	Easy bruising	Fainting
Hoarseness	Chest discomfort	Hepatitis / Jaundice	Pain in legs	Seizures / Tremor
Lumps in neck	Shortness of breath	Gallstones	Joint pain / stiffness	Headaches
Tooth problems	High blood pressure	Diarrhea	Blood clot	Numbness/tingling
Cough	Diabetes	Constipation	Weight loss / gain	Anxiety/Depression
Coughing blood	High cholesterol	Blood in stool	Heat/cold intolerance	Difficulty sleeping

❑ ***Place an "X" in the box to the left if you have none of the above.***

♦ Disease Prevention and Health Maintenance ♦

Please list below the most recent dates of your vaccines and health screening tests

	Month/Yr		***Month/Yr***		***Month/Yr***
Flu Vaccine		Mammogram		Eye Exam	
Pneumonia Vaccine		Pap Smear		Sleep Study	
Prevnar 13 Vaccine		Colonoscopy		Endoscopy (EGD)	
Tetanus Vaccine		Bone Density		Heart Stress Test	
Shingles Vaccine		EKG		Ab Aneurysm Screen	
Shingrix Vaccine		Chest X-Ray		Abdominal Ultrasound	