Ace Health and Wellness Center
14815 N Del Webb Blvd, Sun City, AZ 85351
Ph.(623) 248-1717 | Fax.(623) 248-1688
www.acehealthclinic.com

New Patient Medical History

Last Name:	First Name:	DOB: _____/_____/_____
Previous or referring doctor:		Date of Last Physical Exam: _____/_____/_____

❖ The reason(s) for today's visit:

❖ Personal Health History

Immunizations (Include approximate year or age)	Tetanus Influenza (Flu) Gardasil	Pneumonia/Pnumovax Prevnar Shingles vaccine/ Zostavax	Hepatitis A Hepatitis B

❖ Past or Present Medical History: (check all that apply to you)

Alcohol/ Drug problem	STD/ sexual infection	Neuropathy	Hepatitis
Emphysema/COPD	Abnormal Pap Test	Arthritis	Diabetes
Liver Disease	Blood Clots	Heart- Heart Failure/ CHF	Kidney Disease
Osteoporosis	Anemia	Sleep Apnea	Positive TB test
Prostate problem	Heart – Attack	Asthma	Colon Polyps
Psychiatric- Depression	Peripheral Artery Disease	High Blood Pressure	Dementia
Psychiatric Disorder--other	Anxiety	Heart Murmur	Cancer- Type:
Seizure Disorder	Heart–Coronary Artery Dis.	Atrial Fibrillation	
Stroke	Migraines	High Cholesterol	
Ulcers of the Stomach	Hypothyroidism (low)	Diverticulosis	

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Screening Tests	Approx Date:			Approx Date:	
Cholesterol Test		☐ Normal ☐ Abnormal	Pap Smear		☐ Normal ☐ Abnormal
Colonoscopy/ Cologuard		☐ Normal ☐ Abnormal	Mammogram		☐ Normal ☐ Abnormal
Prostate Test		☐ Normal ☐ Abnormal	Bone Density		☐ Normal ☐ Abnormal
Dental Exam		☐ Normal ☐ Abnormal			
Eye Exam		☐ Normal ☐ Abnormal	☐ Glasses ☐ Contacts ☐ Cataractas		

❖ Allergies/Reactions to Medications:			
Drug Name:	Reaction/Comments:	Drug Name:	Reaction/Comments:

❖ List any food or environmental allergies and reactions:

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❖ Medications: List prescribed and over the counter medications.

Drug name/Dose	Directions:

❖ Surgeries (Include year or age at time of surgery)

☐ Appendectomy	☐ Tonsillectomy	☐ Hysterectomy- Partial
☐ Cardiac Bypass (CABG)	☐ Repair Prostate	☐ Hysterectomy- Total
☐ Cardiac Angioplasty/Stent	☐ Surgery Vasectomy	☐ Tubal Ligation
☐ Gallbladder Laparoscopic	☐ Cataract Surgery: ☐ Left ☐ Right	
☐ Gallbladder Open	☐ C-Section (Cesarean)	☐ Breast Surgery: ☐ Left ☐ Right
☐ Orthopedic (type):		
☐ Other Surgery:		

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❖ Health Habits and Personal Safety

Alcohol

Do you drink alcohol?	No	Yes:	0-1 time/month	2-4 times/month	every month
Each week, how many:	Serving a beer?	Glasses of wine?	Shots/mixed drinks?	
When did you last have more than 4 drinks in one day?			Yes	No
Do you feel you should cut down on drinking?			Yes	No
Do people annoy you by nagging about your drinking?			Yes	No
Have you ever felt guilty about drinking?			Yes	No
Have you ever had a morning drink to steady your nerves?			Yes	No

Drugs

Have you used recreational or street drugs within the last 2 years?	Yes	No
Have you ever used recreational drugs with a needle?	Yes	No

Personal Safety

Do you wear seatbelts?	Yes	No
Do you have frequent falls?	Yes	No
Does your house have a working smoke detector?	Yes	No
Do you experience conflicts in your relationships that take the form of verbally threatening behavior, mental abuse, physical abuse or sexual abuse?	Yes	No

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❖ Family Health History				
Family Member			Age	Medical Conditions (Indicate Healthy or: diabetes, High Blood pressure, cancer & type)
Mother	☐ Living ☐ Deceased			
Father	☐ Living ☐ Deceased			
Grandmother Mother's side	☐ Living ☐ Deceased			
Grandfather Mother's side	☐ Living ☐ Deceased			
Grandmother Father's side	☐ Living ☐ Deceased			
Grandfather Father's side	☐ Living ☐ Deceased			
Sibling	☐ F ☐ M	☐ Living ☐ Deceased		
Sibling	☐ F ☐ M	☐ Living ☐ Deceased		
Sibling	☐ F ☐ M	☐ Living ☐ Deceased		
Sibling	☐ F ☐ M	☐ Living ☐ Deceased		
Sibling	☐ F ☐ M	☐ Living ☐ Deceased		
		☐ Living ☐ Deceased		
		☐ Living ☐ Deceased		

Reviewed by:_____

Date:_____/_____/_____