

Welcome to Bay Valley Medical Group

As a new patient, and to help us understand any health issues you may have, please fill out the information below to the best of your ability.

Patient Name: _____ DOB: _____ Today's Date: _____

PATIENT MEDICAL HISTORY

Please answer "YES" or "NO" if you have ever had any of the following. Leave blank if uncertain.

Measles	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Back Trouble	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Blood/Plasma Transfusion	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Mumps	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Asthma	<input type="checkbox"/> Yes	<input type="checkbox"/> No	High/Low Blood Pressure	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Chickenpox	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Epilepsy	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Bleeding Tendency	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Scarlet Fever	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Bronchitis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Mitral Valve Prolapse	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Diphtheria	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Tuberculosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Bladder Infections	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Smallpox	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	AIDS or HIV	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Pneumonia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Cancer	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Migraine Headaches	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Rheumatic Fever	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Polio	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Kidney Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Whooping Cough	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Heart Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Thyroid Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Glaucoma	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Hepatitis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Other Diseases	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Stroke	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Anemia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	(Please List):		
Ulcer	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Arthritis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____		
Hernia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Hives or Eczema	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____		
Hemorrhoids	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Infectious Mono	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____		
			STD	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____		

Date of last chest X-ray: _____

PREVIOUS HOSPITALIZATIONS/SURGERIES/SERIOUS ILLNESSES

_____	Date: _____
_____	Date: _____
_____	Date: _____
_____	Date: _____

MEDICATIONS (include supplements and over the counter)

Name	Dose/Frequency	Name	Dose/Frequency
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Allergies: _____ **Reaction:** _____

PATIENT SOCIAL HISTORY

Marital status: Single Married Separated Divorced Widowed Living w/partner

Alcohol use: Never Rarely Moderate Daily Amount/day: _____

Caffeine use: Never Rarely Moderate Daily Amount/day: _____

Use of Tobacco: Never Previously, but quit: _____ Current packs/day: _____

Use of drugs: Never Type/frequency: _____

Exercise: Rare Occasional Daily Type of exercise: _____

Special diet: No Yes If so, type: _____

Exposure to: Fumes Dust Solvents Airborne particles Noise

FAMILY MEDICAL HISTORY

Age	Diseases	If deceased, cause of death
Father _____	_____	_____
Mother _____	_____	_____
Siblings _____	_____	_____
_____	_____	_____
Spouse _____	_____	_____
Children _____	_____	_____
_____	_____	_____
_____	_____	_____

Over Please

Review of Systems

CONSTITUTIONAL SYMPTOMS

- Good general health lately Yes No
 Recent weight change Yes No
 Fever Yes No
 Fatigue Yes No
 Snoring / sleep problems Yes No

EYES

- Eye disease or injury Yes No
 Wear glasses or contacts Yes No
 Blurred or double vision Yes No

EAR/NOSE/MOUTH/THROAT

- Hearing loss or ringing Yes No
 Ear pain or drainage Yes No
 Sinus problems Yes No
 Nose bleeds Yes No
 Mouth sores Yes No
 Bleeding gums Yes No
 Bad breath or bad taste Yes No
 Sore throat or voice change Yes No
 Swollen glands in neck Yes No

CARDIOVASCULAR

- Last cholesterol screen _____
 Heart trouble / attack Yes No
 Heart murmur Yes No
 Chest pain / angina Yes No
 High blood pressure Yes No
 Palpitations Yes No
 Shortness of breath while walking or lying flat Yes No
 Swelling of feet or ankles Yes No
 Varicose veins Yes No
 Cold extremities Yes No

RESPIRATORY

- Coughing Yes No
 Coughing up blood Yes No
 Shortness of breath Yes No
 Wheezing / asthma Yes No
 Tobacco use or exposure Yes No

GASTROINTESTINAL

- Colon cancer screen _____
 Loss of appetite Yes No
 Change in bowel movements Yes No
 Nausea or vomiting Yes No
 Frequent diarrhea Yes No
 Painful bowel movements Yes No
 Constipation Yes No
 Abdominal pain Yes No

- Rectal bleeding or blood in stool Yes No

- Heartburn Yes No

GENITOURINARY

- Frequent urination Yes No
 Burning or painful urination Yes No
 Blood in urine Yes No
 Change in urinary stream Yes No
 Incontinence or dribbling Yes No
 Kidney stones Yes No
 Sexual difficulty Yes No
 Male: last PSA _____
 Male: testicle pain Yes No
 Female: painful periods Yes No
 Female: irregular periods Yes No
 Female: vaginal discharge Yes No
 Female: # of pregnancies _____
 Female: # of miscarriages _____
 Female: last menstr. Period _____
 Female: last Pap smear _____
 Female: last mammogram _____

MUSCULOSKELETAL

- Joint pain or stiffness Yes No
 Joint swelling Yes No
 Muscle pain or cramps Yes No
 Back pain Yes No
 Difficulty walking Yes No
 Osteoporosis Yes No

INTEGUMENTARY (skin, breast)

- Rash or itching Yes No
 Change in skin color Yes No
 Change in hair or nails Yes No
 New or changing moles Yes No
 Skin cancer Yes No
 Breast pain Yes No
 Breast lump Yes No
 Breast discharge Yes No

NEUROLOGICAL

- Frequent or recurring headaches Yes No
 Light headed or dizzy Yes No
 Convulsions or seizures Yes No
 Numbness or tingling Yes No
 Tremors Yes No
 Paralysis Yes No
 Head injury Yes No

PSYCHIATRIC

- Memory loss or confusion Yes No
 Nervousness Yes No
 Depression Yes No
 Insomnia Yes No

ENDOCRINE

- Diabetes Yes No
 Thyroid Yes No
 Other glandular or hormone problem Yes No
 Excessive thirst or urination Yes No
 Heat or cold intolerance Yes No
 Skin becoming dryer Yes No

HEMATOLOGIC/LYMPHATIC

- Bleeding / bruising Yes No
 Anemia Yes No
 Phlebitis, DVT, PE Yes No
 Past transfusion Yes No
 Enlarged glands Yes No

ALLERGIC/IMMUNOLOGIC

- Slow to heal after cuts Yes No
 Seasonal allergies Yes No
 Environmental allergies _____
 Food allergies _____
 Immune deficiency or HIV / AIDS Yes No
 Immunizations:
 Hepatitis A _____
 Hepatitis B _____
 Pneumococcal _____
 Influenza _____
 Tetanus _____
 Last PPD (TB test) _____
 History adverse reactions to:
 Penicillin / antibiotics Yes No
 Morphine, Demerol or other narcotics Yes No
 Novocaine / anesthetics Yes No
 Aspirin / other pain meds Yes No
 Tetanus antitoxin or other serums Yes No
 Iodine / other antiseptics Yes No
 Other drugs / medications _____

Authorization & Release: To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information may be dangerous to my health. I authorize the healthcare staff to perform the necessary services I may need. I also authorize Bay Valley Medical Group to obtain copies of medical records from my prior physicians named here.

Prior Physicians: _____

Signature of patient (or parent if minor) _____ Date: _____

Doctor's Review:
