TENNESSEE CENTER of Integrated Medicine

NEW PATIENT MEDICAL HISTORY FORM

Patient Name: _____
Street Address: _____
City/State/Zip: _____
Email: _____
Patient SSN: _____

Preferred Name: _____
Date of Birth: _____
Cell Phone: _____
Home Phone: _____
Other Phone: _____

Emergency Contact Information:
Contact Name: _____
Contact Phone: _____ Relationship: _____

ALLERGIES _____ NO ALLERGIES

ALLERGY	ALLERGIC REACTION

MEDICATIONS

MEDICATIONS *(Please list ALL)*	DOSE *(Mg., pill, etc.)*	TIMES PER DAY

Patient Name:_____
Date of Birth: _____

HEALTH MAINTENANCE SCREENING TEST HISTORY

CHOLESTEROL	Date:	Facility/Provider:	Abnormal Result? Y N
COLONOSCOPY/SIGMOID	Date:	Facility/Provider:	Abnormal Result? Y N
MAMMOGRAM	Date:	Facility/Provider:	Abnormal Result? Y N
PAP SMEAR	Date:	Facility/Provider:	Abnormal Result? Y N
BONE DENSITY	Date:	Facility/Provider:	Abnormal Result? Y N

VACCINATION HISTORY

Last Tetanus Booster or TDap:	Last Pnuemovax *(Pneumonia)*:
Last Flu Vaccine:	Last Prevnar:
Last Zoster Vaccine *(Shingles)*:	

PERSONAL MEDICAL HISTORY

DISEASE/CONDITION	CURRENT	PAST	COMMENTS
Alcoholism/Drug Abuse			
Asthma			
Cancer *(type:_____)*			
Depression/Anxiety/Bipolar/Suicidal			
Diabetes *(type:_____)*			
Emphysema *(COPD)*			
Heart Disease			
High Blood Pressure *(hypertension)*			
High Cholesterol			
Hypothyroidism/Thyroid Disease			
Renal *(kidney)* Disease			
Migraine Headaches			
Stroke			
Other:			

Patient Name:_____
Date of Birth: _____

SURGERIES

TYPE *(specify left/right)*	DATE	LOCATION/FACILITY

WOMEN'S HEALTH HISTORY

Date of Last Menstrual Cycle:	Age of First Menstruation:_____Age of Menopause: _____
Total Number of Pregnancies:	Number of Live Births:
Pregnancy Complications:	

FAMILY MEDICAL HISTORY

o **NO SIGNIFICANT FAMILY HISTORY IS KNOWN**

CHECK ALL THAT APPLY	Alcohol/Drug Abuse	Asthma	Cancer (*type:*)	Emphysema (COPD)	Depression/Anxiety	Bipolar/Suicidal	Diabetes	Early Death	Heart Disease	High Cholesterol	High Blood Pressure	Kidney Disease	Stroke	Thyroid Disease	Migraines	Other:_____	Other:_____	Other:_____
Mother																		
Father																		
Brother																		
Sister																		
Child																		
MGM																		
MGF																		
PGM																		
PGF																		
Other:_____																		

SOCIAL HISTORY

Occupation *(or prior occupation)*:	o Retired o Unemployed o LOA o Disabled
Employer:	Years of Education or Highest Degree:
If employed, do you work the night shift? Y N N/A	
Marital Status *(check one)*: o Single o Partner o Married o Divorced o Widowed o Other:_____	
Do you have children? Y N	If yes, how many?

Patient Name:_____
Date of Birth: _____

ADDITIONAL INFORMATION

Have you traveled outside of the country in the last 30 days? Y N	If yes, where?
Have you served in the military? Y N	If yes, how long and what branch?
Were you deployed? Y N	If yes, where?

OTHER HEALTH ISSUES

TOBACCO USE	Smoke Cigarettes? Y N *(If you never smoked, please move to Alcohol /Drug Use)*		
Current: Packs/day_____# of Years _____	***Past:*** Quit Date:_____Packs/day_____# of Years _____		
Other Tobacco *(check one)*: o Pipe o Cigar o Snuff o Chew			
ALCOHOL/DRUG USE	Do you drink alcohol? Y N	o Beer o Wine o Liquor	# of Drinks/week:
Do you use marijuana or recreational drugs? Y N	Have you ever used needles to inject drugs? Y N		
Have you ever taken someone else's drugs? Y N			
SEXUAL ACTIVITY	Sexually involved currently? Y N *(If no sexual history, please continue to Exercise)*		
Sexual partner(s) is/are/have been: o Male o Female			
Birth control method: o None o Condom o Pill/Ring/Patch/Inj/IUD o Vasectomy			
EXERCISE	Do you exercise regularly? Y N *(If you answered no, please move to Sleep)*		
What kind of exercise?	***Duration:*** How long (min.):_____How often: _____		
SLEEP	How many hours, on average, do you sleep at night *(or during the day, if working night shift)*?		
DIET	How would you rate your diet? o Good o Fair o Poor	Would you like advice on your diet? Y N	
SAFETY	Do you use a bike helmet? Y N	Do you use seat belts consistently? Y N	
Working smoke detector in home? Y N	If you have guns at home, are they locked up? Y N		
Is violence at home a concern for you? Y N	Have you completed an Advance Directive for Health Care (ADHC), Living Will, or Physical Orders for Life Sustaining Therapy (POLST)? Y N		

OTHER PROVIDERS/SPECIALISTS

SPECIALIST	NAME	LAST vISIT
Cardiology		
Gastroenterologist (GI)		
OB/GYN		
Neurology		
Pulmonary		
Other:_____		
Other:_____		

Patient Name:_____

Date of Birth: _____

REVIEW OF SYSTEMS

Please Check All That Apply

Constitution	Cardiovascular	Skin
☐ Activity change	☐ Chest pain	☐ Color change
☐ Appetite change	☐ Leg swelling	☐ Pallor
☐ Chills	☐ Palpitations	☐ Rash
☐ Diaphoresis	**Gastrointestinal**	☐ Wound
☐ Fatigue	☐ Abdominal distention	**Allergy/Immuno**
☐ Fever	☐ Abdominal pain	☐ Environmental allergies
☐ Unexpected weight change	☐ Anal bleeding	☐ Food allergies
Head, Ear, Nose & Throat	☐ Blood in stool	☐ Immunocompromised
☐ Congestion	☐ Constipation	**Neurological**
☐ Dental problem	☐ Diarrhea	☐ Dizziness
☐ Drooling	☐ Nausea	☐ Facial asymmetry
☐ Ear discharge	☐ Rectal pain	☐ Headaches
☐ Ear pain	☐ Vomiting	☐ Light-headedness
☐ Facial swelling	**Endocrine**	☐ Numbness
☐ Hearing loss	☐ Cold intolerance	☐ Seizures
☐ Mouth sores	☐ Heat intolerance	☐ Speech difficulty
☐ Nosebleeds	☐ Polydipsia	☐ Syncope
☐ Postnasal drip	☐ Polyphagia	☐ Tremors
☐ Rhinorrhea	☐ Polyuria	☐ Weakness
☐ Sinus pressure	**Genitourinary**	**Hematologic**
☐ Sneezing	☐ Difficulty urinating	☐ Adenopathy
☐ Sore throat	☐ Dysuria	☐ Bruises/bleeds easily
☐ Tinnitus	☐ Enuresis	**Psychiatric**
☐ Trouble swallowing	☐ Flank pain	☐ Agitation
☐ Voice change	☐ Frequency	☐ Behavior problem
Eyes	☐ Genital sore	☐ Confusion
☐ Eye discharge	☐ Hematuria	☐ Decreased concentration
☐ Eye itching	☐ Penile discharge	☐ Dysphoric mood
☐ Eye pain	☐ Penile pain	☐ Hallucinations
☐ Eye redness	☐ Penile swelling	☐ Hyperactive
☐ Photophobia	☐ Scrotal swelling	☐ Nervous/anxious
☐ Visual disturbance	☐ Testicular pain	☐ Self-injury
Respiratory	☐ Urgency	☐ Sleep disturbance
☐ Apnea	☐ Urine decreased	☐ Suicidal ideas
☐ Chest tightness	**Muscular**	
☐ Choking	☐ Arthralgias	
☐ Cough	☐ Back pain	
☐ Shortness of breath	☐ Gait problems	
☐ Stridor	☐ Joint swelling	
☐ Wheezing	☐ Myalgias	
☐	☐ Neck pain	
☐	☐ Neck stiffness	