Patient Information – Medical History (* required)

First: **Middle:** **Last:**

Age: **Preferred Name or Nickname:**

Patient Gender *: Male ☐ Female ☐

Spouses Name:

Home address:

City: **State:** **Zip:**

Birth Date:
MM/DD/YYYY / /

Home Phone: ( ) –

Cell Phone: ( ) –

Work Phone: ( ) –

Patient Email:

Work status: ☐ Employed ☐ Unemployed ☐ Retired ☐ Disabled from work

Employer: **Occupation:**

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Domestic Partner ☐ Divorced ☐ Separated

Insurance - Primary

This is only needed for prior authorizations of referrals and prescriptions. Please keep this information up to date with our clinic.

Do you have Medicaid or OHP *? ☐ Yes ☐ No

Insurance Company: **Subscriber Name:**

Birth Date:
MM/DD/YYYY / / **Relationship to Patient:**

Policy number : **Subscriber Employer:**

Insurance - Secondary

Do you have Medicaid or OHP *? ☐ Yes ☐ No

Insurance Company: **Subscriber Name:**

Medical History

PCP = Primary Care Provider (previous provider)

PCP Name:

PCP Phone: ( ) – **PCP Fax:** ( ) –

Height * **Weight ***

Do you use tobacco in any form? ☐ Yes ☐ No

If yes, please list type, amount and frequency of use:

Do you use alcohol in any form? ☐ Yes ☐ No

If yes, please list type, amount and frequency of use:

Do you have medication allergies? ☐ Yes ☐ No

If yes, please list the medications.

Please list any past surgery and the year performed.

Please List All Medications. *(Include all over the counter, herbal or natural supplements)*

	Medication Name	Dosage Amount	# Taken Daily	Ordering Provider	Start Date
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					
11					
12					
13					
14					
15					

Have you ever had or been diagnosed to have: (check all boxes that apply)

☐ Cataracts	☐ Kidney Disease
☐ Glaucoma	☐ Kidney Stone(s)
☐ Asthma	☐ Diabetes or Pre Diabetes
☐ Allergies	☐ Thyroid Disease
☐ Stroke	☐ Anemia Bleeding Disorders
☐ Seizures/Epilepsy	☐ Bone or Joint Disease
☐ Hearth Attack or Angina	☐ German Measles
☐ Heart Disease	☐ Rheumatic Fever
☐ Heart Murmur	☐ Chicken Pox
☐ High Blood Pressure	☐ Syphilis
☐ Pneumonia TB/Lung Disease	☐ Depression
☐ Pleurisy	☐ Frequent Infection
☐ Jaundice or Liver Disease	☐ Cancer
☐ Ulcers	☐ High Cholesterol
☐ Digestive Disorder	☐ Prostate Enlargement
☐ Hemorrhoids	☐ HIV
☐ Auto Immune disease(s) (Lupus, Rheumatoid arthritis, etc.)	☐ Lung Disease
☐ Spine Disorders	

Family Medical History

	Age	Health (list significant illness)	Age at Death	If deceased, cause	Comments
Father					
Mother					
Siblings					
1.					
2.					
3.					
4.					
Spouse					
Children					
1.					
2.					
3.					
4.					

Problem List

Please check all problems you are experiencing

Constitutional Symptoms

Good health lately	Yes ☐	No ☐
Recent significant weight change	Yes ☐	No ☐
Unusual fatigue or weakness	Yes ☐	No ☐
Frequent headaches	Yes ☐	No ☐

Eyes

Good health lately	Yes ☐	No ☐
Recent significant weight change	Yes ☐	No ☐
Unusual fatigue or weakness	Yes ☐	No ☐
Frequent headaches	Yes ☐	No ☐

Ears/Nose/Mouth/Throat/Neck

Do you wear hearing aids	Yes ☐	No ☐
Hearing loss or ringing in ears	Yes ☐	No ☐
Earaches or drainage	Yes ☐	No ☐
Chronic sinus problems or runny nose	Yes ☐	No ☐
Nose bleeds	Yes ☐	No ☐
Mouth sores	Yes ☐	No ☐
Bleeding gums	Yes ☐	No ☐
Sore throat/hoarseness or voice change	Yes ☐	No ☐
Lumps or swollen glands in neck	Yes ☐	No ☐
Difficulty swallowing	Yes ☐	No ☐
Neck Pain or stiffness	Yes ☐	No ☐

Cardiovascular

Heart trouble	Yes ☐	No ☐
Chest pain or angina pectoris	Yes ☐	No ☐
Palpitations	Yes ☐	No ☐
Shortness of breath with walking or lying flat	Yes ☐	No ☐
Swelling feet, ankles or hands	Yes ☐	No ☐
Waking at night with shortness of breath	Yes ☐	No ☐
Heart attack	Yes ☐	No ☐
Heart murmur	Yes ☐	No ☐

Respiratory

Chronic or frequent cough	Yes ☐	No ☐
Coughing or spitting up blood	Yes ☐	No ☐
Shortness of breath	Yes ☐	No ☐
Asthma or recurrent wheezing	Yes ☐	No ☐

Gastrointestinal

Loss of appetite	Yes ☐	No ☐
Change in bowel movements	Yes ☐	No ☐
Nausea or vomiting	Yes ☐	No ☐
Painful bowel movements or constipation	Yes ☐	No ☐
Frequent diarrhea	Yes ☐	No ☐
Rectal bleeding or blood in stool	Yes ☐	No ☐
Stomach/abdominal pains or heartburn	Yes ☐	No ☐
Black or tarry stools	Yes ☐	No ☐

Genitourinary

Frequent urination	Yes ☐	No ☐
Burning or pain on urination	Yes ☐	No ☐
Blood in urine	Yes ☐	No ☐
Change in force or strain when urinating	Yes ☐	No ☐
Incontinence or dribbling of urine	Yes ☐	No ☐
Sexual difficulties	Yes ☐	No ☐
Men: Testicular pain	Yes ☐	No ☐
Women: Painful periods	Yes ☐	No ☐
Irregular periods	Yes ☐	No ☐
Recurrent vaginal discharge	Yes ☐	No ☐

Menopausal since when: **Year of hysterectomy:**

Number of pregnancies:

Number of deliveries: **Number of miscarriages:**

Method of birth control:
(if applicable)

Date of last pap smear:

Date of last mammogram:

Musculoskeletal

Joint pain (s)	Yes ☐	No ☐
Joint stiffness/swelling or warmth	Yes ☐	No ☐
Weakness of muscles or joints	Yes ☐	No ☐
Muscle pain or recurrent cramps	Yes ☐	No ☐
Back pain	Yes ☐	No ☐
Cold hands or feet	Yes ☐	No ☐
Difficulty in walking	Yes ☐	No ☐

Integumentary (Skin/Breast)

Rashes or itching	Yes ☐	No ☐
Change in skin color or moles	Yes ☐	No ☐
Change in hair or nails	Yes ☐	No ☐
Varicose veins	Yes ☐	No ☐
Breast pain	Yes ☐	No ☐
Breast lump	Yes ☐	No ☐
Breast discharge or rash	Yes ☐	No ☐

Neurological

Frequent , recurring or increasing headaches	Yes ☐	No ☐
Light-headedness or dizziness	Yes ☐	No ☐
Convulsions, seizures of spasms	Yes ☐	No ☐
Numbness or tingling sensations	Yes ☐	No ☐
Tremors	Yes ☐	No ☐
Paralysis	Yes ☐	No ☐
Stroke	Yes ☐	No ☐
Head injury	Yes ☐	No ☐

Psychiatric

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

Endocrine

Glandular or hormone problem	Yes ☐	No ☐
Heat or cold intolerance	Yes ☐	No ☐
Excessive skin dryness	Yes ☐	No ☐
Excessive thirst or urination	Yes ☐	No ☐
Change in hand or glove size	Yes ☐	No ☐

Hematologic/Lymphatic

Slow to heal after cuts or wounds	Yes ☐	No ☐
Bleeding or bruising tendency	Yes ☐	No ☐
Recurrent anemia	Yes ☐	No ☐
Swelling, warmth or tenderness of veins or history of phlebitis	Yes ☐	No ☐

Allergic/Immunologic (list reactions if applicable)

	Yes
History of skin reaction or other adverse reaction to:	
Penicillin or other antibiotic: describe reaction:	
Morphine, Demerol or other narcotics reaction:	
Novocain or other anesthetics reaction:	
Aspirin or other pain remedies reaction:	
Tetanus antitoxin or other serums:	
Iodine, merthiolate or other antiseptic:	

Other medication you react to:

Other known food allergies:

Type a question:

Is there any specific service and/or concern you would like to inquire about?

I, the undersigned, certify that I (or my dependent) will *not* bill Medicare, Medicaid, OHP nor my provider for any services received at Nicc's Direct Primary Care. I understand I am only considered a member of Nicc's Direct Primary Care if my monthly membership fee is current, that the information I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. Submission of this form does not guarantee my acceptance as a patient of Nicc's Direct Primary Care.

Signature

Date: Click here to enter a date.