Intracoastal Internal Medicine, PA

New Patient Health History Information

Name: _____ **DOB**: _____

Previous primary care provider: _____

Past Medical History: (please check all that apply)

- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial fibrillation
- ☐ Bladder problems
- ☐ Benign prostatic hyperplasia
- ☐ Cancer _____
- ☐ Congestive heart failure
- ☐ COPD
- ☐ Coronary artery disease
- ☐ Crohn's disease
- ☐ Depression
- ☐ Diabetes
- ☐ GERD
- ☐ Heart attack
- ☐ High blood pressure
- ☐ HIV/AIDS
- ☐ High cholesterol
- ☐ Kidney disease
- ☐ Liver disease
- ☐ Seizures
- ☐ Stroke
- ☐ Thyroid disease
- ☐ Other: _____

Surgical History: (please check all that apply)

- ☐ Appendix removal
- ☐ Back surgery
- ☐ Bladder surgery
- ☐ Breast surgery
- ☐ C-section
- ☐ Colon surgery
- ☐ Gallbladder removal
- ☐ Heart surgery
- ☐ Joint replacement
- ☐ Kidney surgery
- ☐ Other: _____

Allergies: (please list all medication allergies)

_____

_____

_____

Name: _____ **DOB**: _____

Family History:

Mother: _____

Father: _____

Sister: _____

Brother: _____

Paternal Grandfather: _____

Paternal Grandmother: _____

Maternal Grandfather: _____

Maternal Grandmother: _____

Medications: (please list all medications OR attach a list)

_____
_____
_____
_____
_____
_____
_____
_____

Social History: (please check one)

Alcohol Use:

☐ None

☐ 2 drinks or less per day

☐ More than 2 drinks per day

Tobacco Use:

☐ Never

☐ Former smoker

☐ Current smoker

Preventative Care: (please put the most recent date)

Colonoscopy: _____ Bone Density Scan: _____

Mammogram: _____ Pap Smear: _____

Immunizations: (please check all that have been completed and the year)

☐ Tetanus: _____ ☐ Shingles: _____ ☐ Covid-19: _____

☐ Influenza: _____ ☐ Pneumonia: _____ ☐ RSV: _____