

*Concierge Family Medicine*  
**New Patient History Worksheet**

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Do we have your **CURRENT** address and phone number? \_\_\_\_\_

**List ALL medicines you are currently taking (include doses):**

**Are you allergic to any medications?**

(Please list) \_\_\_\_\_

**Have you or any of your family members (blood relatives) been diagnosed with the following:  
(Please check ALL that apply)**

- |                                              |                                          |                                         |
|----------------------------------------------|------------------------------------------|-----------------------------------------|
| <input type="checkbox"/> Diabetes            | <input type="checkbox"/> Ulcers          | <input type="checkbox"/> Emphysema      |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Thyroid disease | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> Heart Trouble       | <input type="checkbox"/> Arthritis/Gout  |                                         |
| <input type="checkbox"/> Cancer              | <input type="checkbox"/> Tuberculosis    |                                         |

Have you ever had an overnight stay in a hospital? \_\_\_\_\_

Have you ever had any kind of surgery? (List) \_\_\_\_\_

Have you been immunized against Hepatitis A? \_\_\_\_\_ Hepatitis B? \_\_\_\_\_

Date of last Tetanus Booster Shot \_\_\_\_\_

Date of last HIV test \_\_\_\_\_

If you smoke, how many packs per day? \_\_\_\_\_

Approximate alcohol consumption? \_\_\_\_\_

**Have you recently experienced any of the following:**

**(Please check ALL that apply)**

- |                                               |                                                |                                                  |
|-----------------------------------------------|------------------------------------------------|--------------------------------------------------|
| <input type="checkbox"/> Weight Gain or Loss  | <input type="checkbox"/> Sinus problems        | <input type="checkbox"/> Blood in your stool     |
| <input type="checkbox"/> Muscle/Joint Pains   | <input type="checkbox"/> Mouth/throat problems | <input type="checkbox"/> Hemorrhoids             |
| <input type="checkbox"/> Changes in your skin | <input type="checkbox"/> Cough                 | <input type="checkbox"/> Pain when you urinate   |
| <input type="checkbox"/> Weakness/dizziness   | <input type="checkbox"/> Fever                 | <input type="checkbox"/> Discharge Penis/Vagina  |
| <input type="checkbox"/> Tremor               | <input type="checkbox"/> Chills                | <input type="checkbox"/> Sores on Genitals       |
| <input type="checkbox"/> Headaches            | <input type="checkbox"/> Chest Pain            | <input type="checkbox"/> Menstrual Abnormalities |
| <input type="checkbox"/> Blurred Vision       | <input type="checkbox"/> Shortness of Breath   | <input type="checkbox"/> Depression/Anxiety      |
| <input type="checkbox"/> Double Vision        | <input type="checkbox"/> Breast Pain (or lump) | <input type="checkbox"/> Mood Changes/Swings     |
| <input type="checkbox"/> Pain in your ears    | <input type="checkbox"/> Abdominal Pain        | <input type="checkbox"/> Sexual Desire           |
| <input type="checkbox"/> Difficulty hearing   | <input type="checkbox"/> Nausea/Vomiting       | <input type="checkbox"/> Problems with Erections |
| <input type="checkbox"/> Allergies/Hay Fever  | <input type="checkbox"/> Diarrhea/Constipation |                                                  |

**List any other specific concerns or problems you wish to discuss with Dr. Jones today:**