MERCER ISLAND FAMILY MEDICINE, PLLC

New Patient History

Patient Name: ______________________________ ____________
Last, First Middle

Address: ______________________________

City: __________ Zip: __________ DOB: __________ SSN: __________

Phone, Home: __________ Cell: __________ Work: __________

Emergency Contact: (name & #) ______________________________

Health Maintenance: indicate date, unknown, never, or not applicable.

Last shots Tetanus__________ Flu__________ Pneumonia__________

Last Colonoscopy__________ Due date for next colonoscopy__________

Last eye exam__________ Last Cholesterol__________

Women: Last mammogram__________ Last Pap smear__________

Past Medical and Family History (Please check all that apply)

	Self	Mother	Father	Siblings	Grandparents	Aunts/Uncles
Allergies						
Anemia						
Asthma						
Cancer (type?)						
COPD(Emphysema)						
Depression/Anxiety						
Diabetes						
Heart Attack						
Heart Valve Disease						
High Blood Pressure						
High Cholesterol						
Kidney Disease						
Liver Disease						
STD						
Stroke						
Thyroid Disease						

Other: ______________________________

____

List Current Medications: PLEASE INCLUDE ALL OVER THE COUNTER MEDICATIONS AND VITAMIN SUPPLEMENTS THAT YOU TAKE ON A REGULAR OR AS NEEDED BASIS

Name ______________ dose ______________ how often you take ______________

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____

____

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____

List Past Surgeries: Include dates if known

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____

List Known Drug Allergies:

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____

____

List previous hospitalizations: (Other than childbirth or surgeries)

____

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____

Social History (circle correct answer and fill in blanks)

Smoking history: Current Smoker: Yes ____ No ____ Past Smoker: Yes___ No ____

How much do/did you smoke? ____________ For how long? ________________

When did you quit? __________ Chewing Tobacco: Yes No

Alcohol Consumption: Yes No ________ drinks per day / week / month (circle)?

Illicit/ Illegal drug usage: Yes No

Current Drugs Used:____________________________

Past drugs Used:______________________________

Marital Status: Married widowed single divorced Children: Yes No How many______

Occupation: ____

Educational Level: ____________________________________

Exercise Habits: ______________________________________