Established Patient

Gales Ferry Medical Group

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Gales Ferry Medical Group Interim Heath History Form

In order to minimize necessary paperwork we have changed our history form for established patients. Please make every effort to complete the requested information, even if you believe we have it on record. This is particularly important on the medications you take daily. Please look at your medication bottles from all providers when you complete this form.

Thank you very much.

Patient Name: _____ Today's Date_____
DOB: _____ Pharmacy Name: _____

Has your employment status changed in the past year? Yes No _____
Please provide occupation and employment status _____
Who do you live with? _____
Are you safe in your home? _____
Marital status (S, M, D, W): _____
#Children _____
Please **LIST ALL** medication and the dose you are taking:

_____
_____
_____
_____

Since your last Physical Exam have you experienced any of the following:
Experienced any **NEW** medical condition, procedure, or surgery? (Please list)

_____
_____
_____

Been hospitalized overnight? _____
Developed any **NEW** medication or food allergies? Yes No Please list:

_____
_____

Seen a consultant? (Cardiology, Endocrine, Dermatology, Hematology etc.…)(Please list name and reason):

_____
_____
_____
_____
_____

Please list **ANY CHANGE** in your family history:

Have you received **ANY** immunizations since your last physical? (Please list)

When was your last colonoscopy? _____
When was your last dental visit? _____
When and where was your last eye exam? _____

Do you smoke/vape (circle which applies to you)?

SMOKE VAPE NICOTINE MARJUANA

If you quit smoking how long did you smoke and how many packs per day? _____
If you quit smoking when did you quit? _____

Have you struggled with alcohol or substance now or in the past?	Yes	No
In the past month have you been experiencing little interest or hope?	Yes	No
In the past month have you had little pleasure?	Yes	No
I have fallen in the past year	Yes	No
I use or have been advised to use a cane or walker to get around daily	Yes	No
I steady myself by holding onto furniture when walking at home	Yes	No
I am worried about falling	Yes	No
I need to push with my hands to stand up from a chair	Yes	No
I have some trouble stepping up onto a curb	Yes	No
I often have to rush to the toilet	Yes	No
I have lost feeling in my feet	Yes	No
When I take my medicine I feel light headed	Yes	No
I take medicine to help me sleep or improve my mood	Yes	No
I often feel sad or depressed	Yes	No

Do you have a DNR (do not resuscitate)? _____
Do you have a living will? _____
Do you have a health care proxy or power of attorney? (Please provide an updated copy at your physical) _____

What concerns do you have about changes in your health in the past year?

Since your last physical have you had any of the following problems? (Circle)

Excessive fatigue
Loss of appetite
Night sweats
Rash
Skin trouble
Easy bruise/ bleeding
Transfusions
Varicose veins
Enlarged glands
Frequent headache
Dizziness
Fainting spells
Seizures
Eye trouble
Hearing/ ear trouble
Sinus trouble
Bloody nose
Trouble swallowing
Hemorrhoid

Hay fever
Shortness of breath
Persistent hoarseness
Wheezing
Coughing blood
Chest pain
Palpitation
Swollen ankle
Nausea
Vomiting
Vomiting blood
Yellow skin
Liver trouble
Diarrhea
Constipation
Blood or bloody bowel movement
Heartburn
Bloating/ excess burping

Abdominal pain
Painful urination
Frequent urination
Bloody urine
Genital sore
Swollen joints
Joint pain
Leg cramps
Back pain
Neck pain
Increased thirst
Depression
Excess worry
Thoughts of suicide
Sexual problems
Alcohol trouble
Drug problem
Emotional concern
Breast concern

For Women:

For women how often in the past year have you had more than 4 alcohol beverages in one day?

_____

When was your last mammogram? _____

When was your last pap smear? _____

When was your last bone density? _____

Have your periods changed since your last physical? Yes No If yes in what way?

_____

First day of last menstrual period? _____Type of birth control used: _____

Do you have any unusual vaginal discharge, spotting or bleeding?

For Men:

For men in the how often in the past year have you had more than 5 alcohol beverages in one day?

_____

When was your last prostate examination? _____

Do you have any prostate, urination or unusual discharge trouble? _____

Trouble with erections? _____ Vasectomy? Yes No

Patient Signature _____ **Providers Signature**_____

Patient's printed name_____ **Date**_____

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Patient Name: _____ **Date:** _____

Date of Birth: _____

Please circle YES or NO to the below questions.

Do you feel the urge to urinate regardless of how recently you went to the bathroom?	YES	NO
Do you often wake up two or more times a night to urinate?	YES	NO
Do you avoid going to places where there might not be a bathroom?	YES	NO
Do you often worry that you won't make it to the bathroom on time?	YES	NO
Do you wear panty liners/pads or bring a change of clothes in case of leakage?	YES	NO
Do you urinate more than 8 times in a 24 hour period?	YES	NO