New Patient Medical Information, v. 1

__/__/____
Today's Date

SELF REGIONAL HEALTHCARE
EDGEFIELD MEDICAL CENTER
A Department of Self Regional Healthcare Partners

Patient Demographics

Name SS# DOB

Pharmacy Name Pharmacy Phone Pharmacy Street / City / State

Primary Care Physician Referring Physician

Do you have an Advance Directive? ❑ **Yes** ❑ **No**

Medications *Please list all medications, both prescriptions and over-the-counter, that you are presently taking.*

Medication	Dose/ Strength	How often do you take this medication?	Reason for taking this medication?	Who prescribed this medication for you?

Allergies *Please list all allergies and the reaction that occurred.*

Allergic to?	Describe reaction that occurred:

Medical/Surgical History *Please list **all** medical conditions and previous surgeries.*

Family Medical History

	Illness/Condition	Deceased?	Cause of Death
Father		❑ **Yes** ❑ **No**	
Mother		❑ **Yes** ❑ **No**	
Grandparents		❑ **Yes** ❑ **No**	
Sisters/Brothers		❑ **Yes** ❑ **No**	

Social History

	Type	Amount	Years Quit?
Alcohol			
Caffeine			
Recreational drugs			
Tobacco products			

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Review of Symptoms *Please indicate whether you have experienced any of these symptoms in the **previous six months**.*

		Yes	No
General	Fever/Chills	❑	❑
	Night Sweats	❑	❑
	Weight Loss (____ lbs)	❑	❑
	Jaundice	❑	❑
Eyes	Cataracts or Glaucoma	❑	❑
	Contacts or Glasses	❑	❑
	Distorted Vision	❑	❑
Ears	Hearing Loss/Pain/Ringing	❑	❑
	Dizziness or Vertigo	❑	❑
	Ear Infections	❑	❑
Nose	Congestion	❑	❑
	Runny Nose	❑	❑
	Mouth Breather	❑	❑
	Nosebleeds	❑	❑
Throat	Frequent Sore Throats	❑	❑
	Difficulty Swallowing	❑	❑
	Snoring	❑	❑
	Sleep Apnea	❑	❑
	Daytime Sleepiness	❑	❑
Dental	Dentures: Upper or Lower	❑	❑
	Last Dental Visit: _____ /_____ (*MM/YY*)		
	Dentist: _____		
Heart	Flutter/Palpitations	❑	❑
	Murmur	❑	❑
	High Blood Pressure	❑	❑
	Chest Pain	❑	❑
Lungs	Bronchitis/Chronic Cough	❑	❑
	Asthma/Wheezing	❑	❑
	Shortness of Breath	❑	❑
	COPD/Emphysema	❑	❑
Breast	Lump or Cyst	❑	❑
	Pain or Discharge	❑	❑
	Change in Appearance	❑	❑
	Family History of Breast/Ovarian Cancer	❑	❑
Vascular	Circulation in Arms or Legs	❑	❑
	Aneurysm	❑	❑
	Varicose Veins	❑	❑
	Swelling in Feet/Legs	❑	❑
	Blood Clot	❑	❑

		Yes	No
Abdomen	Indigestion/Heartburn	❑	❑
	Ulcers	❑	❑
	Diverticulitis/Crohn's/Colitis	❑	❑
	Constipation	❑	❑
	Gallbladder Trouble	❑	❑
	Hernia	❑	❑
	Diarrhea	❑	❑
	Nausea/Vomiting	❑	❑
	Change in Bowel Habits/Bloody Stool	❑	❑
	Vomiting Blood	❑	❑
Urinary	Kidney Stones	❑	❑
	Kidney Failure (Dialysis)	❑	❑
	Incontinence	❑	❑
	Painful or Bloody Urination	❑	❑
	Prostate Problems	❑	❑
Endocrine	Thyroid Disorder	❑	❑
	Diabetes	❑	❑
	Hormone Replacement	❑	❑
Hematology	Anemia	❑	❑
Infectious Diseases	Hepatitis	❑	❑
	HIV/AIDS	❑	❑
Skin	Lesion/Rash/Hives	❑	❑
	Psoriasis/Eczema	❑	❑
Psychological	Depression	❑	❑
	Mood Swings	❑	❑
Nervous	Numbness	❑	❑
	Seizures/Convulsions	❑	❑
	Stroke	❑	❑
	Migraine Headaches	❑	❑
Muscles	Weakness of Limbs	❑	❑
	Arthritis	❑	❑
Other *(please list)*			

Females Only *Please complete and check all that apply.*

Pregnant? ❑ **Yes** ❑ **No** **Birth Control Method:** _____

Number of: Pregnancies _____ Abortions _____ Miscarriages _____ Live Births _____