North Bay Medical Associates, P.A.

NAME: ___________________________________ Date: _______________________

PAST MEDICAL HISTORY: (Please check "yes" or "no") If you do not understand something, please ask the nurse for assistance.

Diagnosis:	**Yes**	**No**	**Diagnosis:**	**Yes**	**No**
Hypertension (High Blood Pressure)			Hyperlipidemia (High Cholesterol)		
Diabetes			Coronary Artery Disease		
Atrial Fibrillation			Heart Attack (Myocardial Infarction)		
Heartburn/ Acid Reflux/ Stomach Ulcer			GI Bleeding		
Diverticulitis of the Colon			COPD		
Asthma			Thyroid Problems		
Arthritis/ Joint Problems			Stroke		
Migraine Headaches			Nerve Pain (Neuropathy)		
Anxiety			Depression		
Bipolar Disorder/ Mental Illness			Hepatitis A/B/C		
Colon Cancer			Melanoma		
Deep Vein Thrombosis/Clot in legs			Pulmonary Embolism/Clot in Lungs		
Please list all other problems below:					

SURGICAL HISTORY: Please list **any surgeries** below, along with the **date** you had the surgery done.

SOCIAL HISTORY: (Please write responses where appropriate).

1. Do you smoke? (Yes or No) _______________ **If yes:** How long? _____________ (years) How many packs per day? _______________________ **If no:** Have you ever smoked and when did you quit? ____________________How long did you smoke? _______________________ (years)
2. Do you consume alcohol? (Yes or No) _________ **If yes,** how many drinks per day?__________________________
3. Do you use illicit drugs? (Yes or No)____________ **If yes,** please specify:____________________________
4. Marital Status:__________________________________ Living Situation: ______________________________
5. Work: ____

FAMILY HISTORY: Who had it? **Mom's side or Dad's side** of the family?

DIAGNOSIS	WHO HAD IT?
Heart Disease	
Hypertension (High Blood Pressure)	
Diabetes	
Coronary Artery Disease	
Thyroid Problems	
Breast Cancer	
Colon Cancer	
Lung Cancer	
Prostate Cancer	
Other:	

MEDICATION LIST:
Pharmacy Name and Location: ____
____

MEDICATION NAME AND DOSAGE	HOW OFTEN?

ALLERGIES (FOOD, MEDICINE, POLLENS, OTHER):

ALLERGIC TO:	WHAT TYPE OF REACTION?
1.	
2.	
3.	
4.	
5.	

HEALTH MAINTENANCE:

HAVE YOU HAD A:	YES	NO	WHAT YEAR?	RESULTS? (NORMAL OR ABNORMAL)
Colonoscopy				
Eye Exam				
Females Only:				
Mammogram				
Pap Smear				

If you are of childbearing age: Are you Pregnant? ____

VACCINES (ADULTS AND CHILDREN): (Parents of new patients: Please provide us with a **vaccine record** for your child).

HAVE YOU HAD A:	YES	NO	WHAT YEAR?
Flu Shot			
Pneumonia Shot			
Tetanus Shot			
Zostavax (Shingles Vaccine)			
Other Vaccines:			

Thank you for taking the time to fill out this form which has helped us to give you quality healthcare and serve you better. If you have any questions, please feel free to ask us!