Commonwealth
Medical Physician Group

Lakeview's premier independent internal medicine primary care physicians

New Patient Information

Date *

Patient First Name * Patient Last Name *

Address *

Birth Date *

Day Month Year

Have you ever been in the hospital or had surgery? If yes for what and when? *

Pregnancies

Total Number of Pregnancies

Number of Children Number of Miscarriages Number of Abortions

Medical History

Please check all past or present medical problems and/or symptoms

- [ ] Anemia
- [ ] Arthritis
- [ ] Asthma
- [ ] Cancer
- [ ] Diabetes
- [ ] Fibroids
- [ ] Glaucoma
- [ ] Gout
- [ ] Hearing Loss
- [ ] Visual Loss
- [ ] Chest Pain
- [ ] Heart Attack
- [ ] Heart Disease
- [ ] High Blood Pressure
- [ ] Any Other Bleeding
- [ ] Gastrointestinal Bleeding
- [ ] Easy Bruising
- [ ] HIV
- [ ] Kidney Disease
- [ ] Liver Disease
- [ ] Lung Disease
- [ ] Shortness of Breath
- [ ] Prostate Disease
- [ ] Psychiatric Problems
- [ ] Alcoholism
- [ ] Drug/Substance Abuse
- [ ] Seizures
- [ ] Stroke
- [ ] Sexually Transmitted Disease
- [ ] Abnormal Penile Discharge
- [ ] Abnormal Vaginal Discharge
- [ ] Thyroid Disease
- [ ] Tuberculosis
- [ ] Ulcers
- [ ] Urinary Incontinence
- [ ] Difficulty Urinating

Medication History: Please list medications you are currently taking

Medication | How Often?

For what problem?

Medication | How Often?

For what problem?

Medication | How Often?

For what problem?

Medication | How Often?

For what problem?

Medication | How Often?

For what problem?

Medication | How Often?

For what problem?

Allergies

Social History

Do you smoke? * If yes, how much and how often do you smoke?

Yes No

Do you drink alcohol? * If yes how often and how much do you drink alcohol?

Yes No

Do you use illicit drugs? * If yes what kind and how often do you use illicit drugs?

Yes No

What is your occupation?

Is there any exposure to dust, fumes, smoke, or noise?

Are you watching your diet or following any strict dietary guidelines?

Family History

Father's Age	Father's Medical Problems or Cause of Death
"not living" or current age	

Mother's Age	Mother's Medical Problems or Cause of Death
"not living" or current age	

Other relationship	Other's Age
	"not living" or current age

Other's Medical Problems or Cause of Death

Health Screenings/Immunizations

Pap Smear Date and Results

Stress Test Date and Results

Mammogram Date and Results

Bone Density Date and Results

Chest X-ray Date and Results

Physical Examination Date and Results

Digital Rectal Exam Date and Results

Prostate Examination/PSA Date and Results

Stool Hemoccults Date and Results

Flexible Sigmoidoscopy Date and Results

Colonoscopy Date and Results

Cholesterol Date and Results

Blood Sugar Date and Results

Tuberculosis/PPD Test Date and Results

Influenza Vaccine Date

Tetanus/TD Date

Hepatitis B Vaccine Date

Pneumococcal Vaccine Date

Shingles Vaccine Date

B.M.I. Date and Results