New Patient Form

Full Legal Name _____ **Date of Birth** _____

The Medical Group of Columbia **Provider** _____ **Appointment Date** _____

NURSING ENCOUNTER FORMS (Please Print)

Gender ☐ M ☐ F Age _____ Which hand do you write with? ☐ Right ☐ Left

CHIEF COMPLAINT

What is your reason for seeing the Doctor? _____

_____

HISTORY OF PRESENT ILLNESS

How long have you had symptoms? _____

Are symptoms getting worse, better or same? _____

Have you had these symptoms before? _____

What makes symptoms better? _____

What makes symptoms worse? _____

Have you seen another doctor for these symptoms? ☐ Yes ☐ No If yes, who? _____

Was medication prescribed? ☐ Yes ☐ No If yes, what? _____

MEDICAL SPECIALISTS (other doctors, therapies, home health, medical equipment etc.)

Provider	Specialty	Last Seen

The Medical Group of Columbia
Dr. Kennedy and Associates
AdvancedHEALTH

Phone 931.388.8802 * 1609 Rosewood Dr Columbia TN 38401 * Fax: 931.490.2292

Medication List

Full Legal Name _____ **Date of Birth** _____

Preferred Pharmacy _____ **Location** _____ **Phone** _____

MEDICATION ALLERGIES

Medication	Reaction	Medication	Reaction

MEDICATION LIST

Medication	Dosage (mg, mcg, ccs)	How many times each day do you take it?

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Patient History Past Medical History

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PAST MEDICAL HISTORY

- ☐ Alcohol Abuse
- ☐ Allergy / Hay Fever
- ☐ Anemia / Low Blood Count
- ☐ Arrhythmias (irregular heart beat)
- ☐ Arthritis
- ☐ Asthma
- ☐ Automobile Accident with Injuries
- ☐ Bleeding Problems
- ☐ Brain Tumor
- ☐ Back Injury
- ☐ Cancer - Type _____
- ☐ Cervical Spine Disease / Neck Problems
- ☐ Circulation Problems
- ☐ Colonic Polyps
- ☐ Congestive Heart Failure
- ☐ Dementia
- ☐ Diabetes
- ☐ Drug Use
- ☐ Hormone Abnormalities
- ☐ Emphysema / Lung Disease
- ☐ Epilepsy / Seizures
- ☐ Genital / Urinary Disease
- ☐ Head Injury
- ☐ Headache / Migraine
- ☐ Headache / Tension
- ☐ Heart Attack
- ☐ High Blood Pressure
- ☐ HIV / Aids
- ☐ Liver Disease / Hepatitis
- ☐ Loss of Consciousness
- ☐ Lumbar Spine Disease / Low Back Pain
- ☐ Measles
- ☐ Meningitis
- ☐ Menstrual / Sexual Dysfunction
- ☐ Mumps
- ☐ Murmur
- ☐ Neck Injury
- ☐ Neuromuscular (disease of muscles)
- ☐ Nerve Damage (disease of nerves)
- ☐ Peptic Ulcer Disease
- ☐ Pneumonia
- ☐ Polio
- ☐ Renal / Kidney Disease
- ☐ Rheumatic Fever
- ☐ Sexually Transmitted Disease
- ☐ Shingles
- ☐ Smoking
- ☐ Spinal Cord Injury
- ☐ Stroke (symptoms: _____)
- ☐ Thyroid Disease

Please list any other conditions for which you have been treated: _____

_____

PREVENTATIVE MEDICAL HISTORY (give date of last)

Test	Date
Colonoscopy	
Mammogram	
Bone Density	
Eye Exam	
Pap smear (women only)	

Vaccination	Date

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Patient History Surgical

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SURGICAL HISTORY

SURGERY	DATE	SURGEON	PLACE
Appendectomy / Appendicitis			
Amputation			
Arthroscopy / Knee Surgery			
Brain Aneurysm			
Brain Surgery			
Cardiac Bypass / Open Heart Surgery			
Carotidendarterectomy (artery in the neck)			
Cataract / Eye Surgery			
Cesarean Section			
Cholecystectomy / Gall Bladder			
Hemorrhoidectomy			
Hernia Repair (Groin/Stomach/Belly)			
Hysterectomy			
Laparoscopy (Abdomen)			
Mastectomy (Breast Surgery)			
Neck Surgery			
Pacemaker Installed			
Prostate Surgery			
Tonsillectomy			
Tubal Ligation			
Ulcer			
Vasectomy			
Other			

Please list any other information that you feel is relevant to your doctor visit today:

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Patient History Family/Social

Full Legal Name _____ **Date of Birth** _____

FAMILY HISTORY

Please Check Appropriate Answer

Mother Living?	☐ Yes	☐ No
Healthy?	☐ Yes	☐ No
Father Living?	☐ Yes	☐ No
Healthy?	☐ Yes	☐ No
Brothers Living?	☐ Yes	☐ No
Healthy?	☐ Yes	☐ No
Sisters Living?	☐ Yes	☐ No
Healthy?	☐ Yes	☐ No

If any of your immediate family is deceased, please give age and cause of death.

List any disease or illnesses that run in your family.

Does anyone in your family have any of the following conditions?
If so check the box and list the family member (mother, father, sister, brother, etc.)

- ☐ Arthritis _____
- ☐ Bleeding Disorder _____
- ☐ Brain Aneurysm _____
- ☐ Brain Tumor _____
- ☐ Cancer _____
- ☐ Diabetes _____
- ☐ Dementia _____
- ☐ Epilepsy _____
- ☐ Heart Disease _____
- ☐ High Blood Pressure _____
- ☐ Kidney Disease _____
- ☐ Migraine / Headache _____
- ☐ Numb Hands or Feet _____
- ☐ Stroke _____
- ☐ Thyroid Disease _____
- ☐ Other _____

SOCIAL HISTORY

Are you a smoker? ☐ Yes ☐ No How many packs a day? _____ How long have you smoked? _____

Have you ever smoked? ☐ Yes ☐ No For how long? _____ When did you quit? _____

Do you drink alcohol? ☐ Yes ☐ No How much? _____ How often? _____ Type? _____

Have you used street drugs? ☐ Yes ☐ No If yes, what type? ☐ Marijuana ☐ Heroin ☐ Cocaine ☐ IV Drugs

Do you still use street drugs? ☐ Yes ☐ No If yes, how often? _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

How far did you go in school? _____ Occupation / Job? _____

Number of children? _____ Who lives in your household? _____

Do you have difficulty with ☐ Preparing meals ☐ Bathing ☐ Dressing / Grooming ☐ Tolieting

SEXUAL HISTORY

Have you been sexually active in the last 12 months? ☐ Yes ☐ No Type of contraception _____

WOMEN ONLY: Date of last menstrual period? _____ Are you pregnant? ☐ Yes ☐ No

Number of Pregnancies _____ Births _____

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Patient History Review of Systems

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REVIEW OF SYSTEMS

Yes	No		
☐	☐	**General Symptoms**	Fever chills, headache, loss of appetite Weight loss or weight gain
☐	☐	**Eyes**	Blurred or double vision, eye pain, blindness
☐	☐	**Ear, Nose, Throat, Mouth**	Ear infection, sore throat, sinus problem vertigo/spinning sensation; problems with taste or smell
☐	☐	**Respiratory**	Wheezing, cough, shortness of breath, Coughing up blood or sputum
☐	☐	**Cardiovascular**	Chest pains, heart murmurs, racing heart, irregular rhythm
☐	☐	**Gastrointestinal**	Constipation, stomach pain, nausea, diarrhea, vomiting
☐	☐	**Bladder / Urinary Tract**	Cancer, stones, recurrent infections
☐	☐	**Musculoskeletal**	Arthritis, joint pain, back pain, muscle pain, cramps
☐	☐	**Skin**	Rash, itching, boils, dry skin, oily skin, changes in moles
☐	☐	**Neurologic**	Seizures, numbness, tingling, dizziness, stroke, weakness, fainting, loss of vision, inability to speak
☐	☐	**Psychologic**	Depression, anxiety, memory problems
☐	☐	**Endocrine**	Tired, excess thirst, too hot / cold
☐	☐	**Hematologic / Lymphatic**	Bleeding problems, swollen glands
☐	☐	**Allergic / Immunologic**	Seasonal allergies, AIDS
☐	☐	**Sleep**	Snoring, increased daytime sleepiness, difficulty falling asleep, difficulty staying asleep, falling asleep while driving, frequent daytime naps
☐	☐	**Walking**	Shuffling, small steps, off-balance staggering, stumbling, tripping walking on outside of feet, problems getting up from chair or out of bed

Explain any Yes answers:

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