Ivinson MEMORIAL HOSPITAL
MEDICAL GROUP

New Patient

Patient Information

Name (Last, First, Middle):_____

Preferred Name:_____ Date of Birth:_____ Age:_____

Address:_____ City, State:_____

Phone:_____ Email:_____

Preferred Contact Method: ☐Phone ☐Text ☐Email ☐Mail

Employer:_____ Occupation:_____

Local Pharmacy:_____ Mail Order Pharmacy:_____

Current Medications / Supplements		☐**See attached medication list.**
Medication / Supplement	Dose	Frequency

Allergies	☐**See attached allergy list.**
Medication or Substance	Reaction

Medical History: Do you have any health problems? (check all that apply)

☐ADHD	☐Depression	☐Mental Health Concerns
☐Anxiety	☐Diabetes	☐Migraines / Headaches
☐Arthritis	☐GERD / Heartburn	☐Psoriasis
☐Asthma	☐Heart Problems	☐Pulmonary Embolism
☐Bladder / Kidney Problems	☐Hepatitis	☐Rheumatoid Arthritis
☐Bleeding Problems	☐High Blood Pressure	☐Seasonal Allergies
☐Blood Clots / Stroke	☐High Cholesterol	☐Serious Injuries / Accidents
☐Cancer	☐HIV	☐Sleep Apnea
☐COPD	☐Hospitalizations other than childbirth	☐Stomach / Bowel Problems
☐Crohn's Disease	☐Liver Problems	☐Thyroid Problems
☐Dementia	☐Lupus	☐Ulcerative Colitis

Explain checked items and any other health problems:_____

_____

_____

Surgical History

Surgical Area or Procedure	Year completed and other details
Appendectomy	
Bone / Joint Surgery	
EGD	
Colonoscopy	
Gallbladder Surgery	
Hernia Repair	
Hysterectomy	
Cancer (specify location)	
Ear / Nose / Throat	
Tubal Ligation	
Vasectomy	
Wisdom Teeth	
Other	

Family History ☐Adopted ☐Family History Unknown

Is your mother alive? ☐Yes ☐No Age:_____

If deceased, at what age and cause of death?_____

Mother's medical problems?_____

Is your father alive? ☐Yes ☐No Age:_____

If deceased, at what age and cause of death?_____

Father's medical problems?_____

Family Medical Problems: Do any of your immediate family members have any of the following medical problems?

Medical Problem	**Family Member(s)** (brother, sister, mother, father, paternal/maternal grandparents)
Cancer (specify type)	
Blood Clot or Stroke	
Diabetes	
Heart Disease	
High Blood Pressure	
Thyroid Problems	
Other	

Social History

Marital Status: ☐Single ☐Married ☐Divorced ☐Separated ☐Widowed

Do you smoke cigarettes or e-cigarettes?..... ☐Current ☐Past ☐Never

How much?_____ How many years?_____ When did you quit?_____

Do you use chewing tobacco, snuff, or other forms of tobacco? ..... ☐Current ☐Past ☐Never

List what type:_____

Do you use recreational drugs (marijuana, etc.)? ..... ☐Current ☐Past ☐Never

List what type:_____

Do you drink alcohol?..... ☐Current ☐Past ☐Never

How many glasses of wine, liquor, mixed drinks, or beer per week?_____

New Patient

Immunization History	
Immunization	**Date**
Tdap (tetanus, diphtheria and pertussis)	
Tetanus	
Pneumonia Vaccine (PCV 23)	
Prevnar (PVC 13)	
Prevnar (PVC 20)	
Shingrix (shingles)	
Zostavax (shingles)	
Influenza (flu)	
Hepatitis (A/B)	
Meningococcal (Meningitis)	
Gardasil (HPV)	
COVID-19 (SARS-CoV-2)	

Health Maintenance	
Test / Procedure	**Date**
Bone Density (DEXA)	
Mammogram	
Pap Smear	
Prostate Screen (PSA)	
Colonoscopy	

System Review: Please check all that currently apply.

☐Poor Appetite	☐Cough	☐Depression	☐Sore Throat
☐Weight Gain	☐Shortness of Breath	☐Trouble Sleeping	☐Hoarseness
☐Weight Loss	☐Rash on Skin	☐Voice Change	☐Lumps and/or Nodules
☐Fever	☐Hair/Nail Problems	☐Dental/Gum Issues	☐Snoring
☐Chills	☐Itching	☐Throat Discomfort	☐Nosebleeds
☐Excess Sweating	☐Headaches	☐Heartburn/Indigestion	☐Swollen Glands
☐Fatigue	☐Increased Thirst	☐Difficulty Swallowing	☐Bruise or Bleed Easily
☐Temperature Intolerance	☐Increased Urine Volume	☐Special Food Intolerance	☐Muscle/Joint Pain
☐Ear Pain	☐Urinary Incontinence	☐Abdominal Pain	☐Numbness/Weakness
☐Ear Drainage	☐Bloody Sputum	☐Constipation	☐Faulty Memory
☐Ear Blockage	☐Wheezing	☐Diarrhea	☐Eye Pain/Redness
☐Ringing in Ears	☐Chest Pains	☐Vomiting	☐Visual Disturbances
☐Hearing Loss	☐Heart Palpitations/Skipping	☐Vomiting Blood	
☐Dizziness	☐Edema	☐Nasal Congestion	
☐Fainting	☐Nervousness	☐Nasal Drainage	