APPLEGATE VALLEY FAMILY MEDICINE
NEW PATIENT MEDICAL REVIEW

NAME__________________________ AGE ________ DATE OF BIRTH __________________________

Do you have a POLST or advanced directive on file? ____

What recreational interests do/did you have? ____

(If needed, please attach an additional page to complete the following questions)

MEDICATIONS AND DRUG ALLERGIES

PLEASE ATTACH MARS (PROVIDED BY FACILITY)

PAST MEDICAL HISTORY

If you have had any of these medical problems, please circle them and write in the date you were first told you had that problem.

AIDS	Cough (ongoing)	Hearing Loss	Liver Disease
Anemia	Chronic Pain	Heart Attack	Osteoporosis
Anxiety	Deep Vein Thrombosis	Heart Murmur	Seizure Disorder
Angina (chest pains)	Dementia	Hepatitis	Stroke or TIAs
Arthritis/ Osteoarthritis	Depression	High cholesterol	Urinary Concerns
Back Pain	Diabetes Type I or II	High Blood Pressure	Vertigo/ Dizziness
Bipolar Disorder	Edema	Insomnia	Vision Loss
COPD/emphysema	Esophageal Reflux	Kidney Disease	

Other medical problems. Please list: ____
____

If you have had any of these surgical procedures, please circle them and write in the date.

Appendectomy	C-Section	Endoscopy	Mastectomy
Amputation	Carpal Tunnel Release	Hernia Repair	Melanoma Removal
Back Surgery	Colonoscopy	Hysterectomy	Tonsillectomy

Operations. Please list: ____

Smoking – current use (packs per day) ____________________ Past use: Packs per day and years ____________________

Alcohol – current use ____________________ Average use in the past ____________________

Recreational drugs – current use____________________ Past use: ____________________

FAMILY MEDICAL HISTORY

Has any blood relative had any of the following problems? (**circle**)

Alzheimer's Disease	Dementia	Heart Disease	Stroke
Anemia	Diabetes	High Blood Pressure	Sudden Death
Cancer (type) ______	Hearing Loss	Mental Health Issues	Vision Loss

Other family medical problems. Please list: ____
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SIGNATURE______________________________ DATE COMPLETED ____________________