Memorial Hermann Medical Group
New Patient Medical History - PCMH

Today's Date: _____

Patient Name: _____ Date of Birth: _____

Email: _____

Reason for your visit: _____

How did you hear about us? _____

SPECIALISTS

Please list any other doctors you see.	Specialty

FAMILY MEDICAL HISTORY

Please mark any conditions in your family.

CONDITION	FATHER	MOTHER	BROTHER	SISTER	OTHER
Anxiety					
Asthma					
Blood/clotting disorder					
Cancer (what kind?)					
Diabetes					
Dementia					
Depression					
Heart attack (what age?)					
High blood pressure					
High cholesterol					
Kidney disease					
Stroke					
Thyroid disease					
Other					

PERSONAL MEDICAL HISTORY

Please mark any conditions that apply to you.

- ☐ Anxiety
- ☐ Asthma
- ☐ Blood/clotting disorder
- ☐ Cancer: _____
- ☐ Covid
- ☐ Depression
- ☐ Diabetes
- ☐ Emphysema (COPD)
- ☐ Heart attack (what age?) _____
- ☐ Heart disease (blocked arteries)
- ☐ Heart failure
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Kidney disease
- ☐ Osteoporosis
- ☐ Stroke
- ☐ Thyroid disease
- ☐ Other: _____

SURGICAL HISTORY

Please list any surgeries you've had.	Date

HEALTH MAINTENANCE

Have you had these vaccines (shots)?	Yes (Date)	No
Chicken Pox		
Covid		
Flu		
Meningitis		
Pneumonia (Prevnar, Pneumovax)		
Shingles (Zostavax, Shingrix)		
Tetanus		

Have you had these tests?	If Yes, please list date (month/day/year) and results.	No
Bone Density Screening		
Colorectal Cancer Screening		
o Colonoscopy		
o Fecal immunochemical test (FIT-DNA) (Ex: Cologuard)		
o Fecal occult blood test (FOBT) (Ex: Hemoccult Sensa)		
o Other - List name of test		
Diabetic Eye Exam		
Mammogram		
Pap Smear		

SOCIAL HISTORY

Tobacco Use: ☐ Current every day ☐ Current some days ☐ Former ☐ Never

Type (if applicable): _____

Tobacco Exposure: ☐ None ☐ At Work ☐ At Home

You are a current or past smoker, have you smoked in the last year? ☐ Yes ☐ No

Alcohol Use: * How often did you have a drink containing alcohol in the past year:

☐ Never ☐ Monthly or less ☐ 2-4 times/month ☐ 2-3 times/week ☐ 4 or more times/week

* How many drinks did you consume on a typical day when you were drinking in the past year?

☐ 1-2 ☐ 3-4 ☐ 5-6 ☐ 7-9 ☐ 10 or more

* How often did you have 6 or more drinks on one occasion in the past year?

☐ Never ☐ Less than monthly ☐ monthly ☐ Weekly ☐ Daily or almost daily

* Type of Alcohol: ☐ Beer ☐ Wine ☐ Liquor

Substance Use: ☐ Current ☐ Past ☐ Never

Type (if applicable): _____

Exercise: ☐ No Exercise ☐ Light Exercise ☐ Moderate Exercise ☐ Vigorous/High Intensity Exercise

If you exercise, how many days per week? _____

If you exercise, how many minutes per session? _____

Occupation: _____ ☐ Student ☐ Retired ☐ Unemployed

OBSTETRICAL HISTORY

Have you ever been pregnant? ☐ N/A ☐ No ☐ Yes

If yes, list pregnancies here: _____

DATE/YEAR	WEEKS AT BIRTH	DELIVERY: VAGINAL, CESAREAN, PREGNANCY LOSS, ETC	CHILD SEX

Did you have any complications during your pregnancies? ☐ N/A ☐ No ☐ Yes

If yes, please describe: _____

_____

MEDICATIONS

☐ **I am not taking any medications.**

☐ **I brought a list of my medications from home. [You do not need to write down your medications if you brought a complete list].**

List all medications prior to assessment. Include over-the-counter, alternative medications, herbals and prescriptions.

MEDICATION NAME	STRENGTH	NUMBER OF PILLS AT ONE TIME?	HOW MANY TIMES A DAY?	PRESCRIBER	TAKING AS PRESCRIBED?
Example: *Tylenol*	*100mg*	*1*	*2*	*Dr. Smith*	☒ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No

Local Pharmacy: _____ Phone Number: _____

Mail Order Pharmacy: _____ Phone Number: _____

ALLERGIES

☐ **No Known Allergies**

MEDICATION / FOOD / ENVIRONMENTAL	REACTION	SEVERITY
		☐ Mild ☐ Moderate ☐ Severe
		☐ Mild ☐ Moderate ☐ Severe
		☐ Mild ☐ Moderate ☐ Severe
		☐ Mild ☐ Moderate ☐ Severe
		☐ Mild ☐ Moderate ☐ Severe
		☐ Mild ☐ Moderate ☐ Severe
		☐ Mild ☐ Moderate ☐ Severe

I have completed the above to the best of my knowledge.

Patient / Guardian Signature	Print Name	Relationship to patient	Date	Time
				☐ AM ☐ PM