Mending Hearts Primary Care, LLC

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New Patient Personal History

Name:____**Date:** ____________________

Reason for Visit:____

Where have you been receiving your medical care?

Name of Physician:____

DRUGS AND MEDICATION:
List all medication you take, including dosage and how often(this includes home remedies, herbal supplements, birth control inhalers, non-prescriptions):

Name of Medication	Dose or Strength	How often do you take it?

Have you ever had an allergic reaction to a medication? □ No □ Yes……………**If yes, which medication(s)?**

Medication	Reaction

Have you ever had an allergic reaction to any of the following?

Latex	□ No □ Yes	**Iodine**	□ No □ Yes	**Other allergies**______________________	
Insect stings	□ No □ Yes	**Food**	□ No □ Yes	**(If Yes, describe)**____________________	

Do you chew tobacco or snuff? □ No □ Yes ……………………………………………… **Do you smoke cigars or cigarettes?** □ No □ Yes
If yes, how much_____________day   How long?___________years

Do you drink alcohol? □ No □ Yes…………………………… What type?_________________________________
If yes, how much_____________day   How long?___________years

Please list all Surgeries below with dates and Reason.	Please list all Hospitalizations below with dates and Reason.

Family History: Have any members of your family, (including grandparents, parents, siblings, and children), had any of the following:

Problem	Circle Yes or No		Family Relationship
High Blood Pressure	Yes	No	
Diabetes	Yes	No	
Heart Disease/Angina	Yes	No	
High Cholesterol	Yes	No	
Stroke	Yes	No	
Cancer (Breast, Ovarian, Colon, Other)	Yes	No	
Anemia/Bleeding Problems	Yes	No	
Other (Please Describe):	Yes	No	

Past Medical History: Please circle Yes or No for any illnesses that you have had:

Anemia	Yes	No
Arthritis	Yes	No
Asthma/ Bronchitis/ Emphysema	Yes	No
Bleeding/ Bruising	Yes	No
Blood Disorder	Yes	No
Cancer (type):	Yes	No
Depression/ Emotional Problems	Yes	No
Diabetes	Yes	No
Drug/ Alcohol Dependency	Yes	No
Epilepsy/ Seizures	Yes	No
Hay Fever/ Sinus Problems	Yes	No
Hearts Problems	Yes	No

Hepatitis	Yes	No
High Blood Pressure	Yes	No
Immune Disorders	Yes	No
Intestinal Problems	Yes	No
Kidney Disease	Yes	No
Liver Disease	Yes	No
Lung Disease	Yes	No
Skin Disease	Yes	No
Stroke	Yes	No
Stomach Ulcers	Yes	No
Thyroid Disease	Yes	No
Other (describe)	Yes	No

Preventive Care:

Have you received a vaccines to prevent any of the following diseases? If yes, please list date:

Tetanus (Tdap): □ No □ Yes Date__________________ Influenza(flu): □ No □ Yes Date__________________

Pneumonia: □ No □ Yes Date__________________ COVID: □ No □ Yes Date__________________

Have you ever had any to prevent any of the following diseases? If yes, please list date:

Colonoscopy: □ No □ Yes Date__________________ Dexa Scan: □ No □ Yes Date__________________

Mammogram: □ No □ Yes Date__________________ Lung CT screen: □ No □ Yes Date__________________

END OF PATIENT PERSONAL HISTORY.