Name: _____

DOB: _____

FAMILY CARE
SOUTHWEST, P.C.

Fax (303) 933-8147
Mail 6169 S Balsam Way, #250, Littleton CO 80123

New Patient Medical History Form

Allergies: _____

Preferred Pharmacy: (name and location):

_____

Prescription Medication, Vitamins, Supplements: □ NONE

1) _____ Dosage: _____# of times a day: _____
2) _____ Dosage: _____# of times a day: _____
3) _____ Dosage: _____# of times a day: _____
4) _____ Dosage: _____# of times a day: _____
5) _____ Dosage: _____# of times a day: _____

Past Medical History

□ Anxiety	□ Blood Clots	□ Gallbladder Disease	□ Osteoporosis
□Arthritis	□ Cancer	□ GERD (reflux)	□ Peptic Ulcer Disease
□ Allergies	□ Chest Pain	□ Heart Attack	□ Prostate Enlargement
□ Anemia	□ COPD	□ Kidney Disease	□ High Blood Pressure
□ Asthma	□ Crohn's Disease	□ High Cholesterol	□ Atrial Fibrillation
□ Angina	□ Depression	□ Heart Disease	□ Thyroid Disease
□ Liver Disease	□ Migraines - Headaches	□ Irritable Bowel Disease	□ Coronary Artery Disease
□ Hepatitis B or C	□ Diabetes	□ Seizure Disorder	□ Bladder reflux
□ Osteoarthritis	□ Colitis / Diverticulitis		

Other: _____

_____

Name: _____

DOB: _____

Past Surgical History- Please list the year procedure was done

□ Angioplasty _____ □ Colectomy_____ □ Bone Surgery _____

□ Angioplasty with Stent _____ □ Colostomy_____ □ Pacemaker_____

□ Appendectomy _____ □ Gastric Bypass_____ □ Small Bowel Resection _____

□ Hernia Repair _____ □ Thyroidectomy_____ □ Tonsillectomy_____

□ Joint Replacement R/L Hip (please indicate) _____

□ Joint Replacement R/L Knee (please indicate) _____

□ Back Surgery _____ □ Carpal Tunnel R/L _____

□ LASIK _____ □ Cataract Extraction _____

□ Gallbladder Removal _____ □ Liver Biopsy _____

□ Heart Bypass _____ □ Tubal litigation _____

□ TURP (prostate) _____

Other: _____

Females Only:

□ Bone Density Date __/__/__ Normal? □ Yes □ No

□ Colonoscopy Date __/__/__ Normal? □ Yes □ No

□ Last Period __/__/__ □ Date of last Pap __/__/__ □ History of abnormal pap? Y or N Year _____

□ Treatment for abnormal pap □ Freezing, LEEP or Observation (circle one)

□ Hysterectomy? □ Yes □ No Year _____

□ Postmenopausal? □ Yes □ No Year _____ □ Post-menopausal bleeding? □ Yes □ No

□ Hormone Replacement Therapy? □ Yes □ No Year Started_____ □ Total Pregnancies: _____

□ Gardasil Vaccine? □ Yes □ No □ History of STD's □ Yes □ No

□ Contraception (type) _____

□ Sexual Partners in Lifetime □ < 5 □ > 5 □ > 10

Name: _____

DOB: _____

Males Only

□ Colonoscopy Date ___/___/_____ Normal? □ Yes □ No

□ Prostate Exam Date ___/___/_____ Normal? □ Yes □ No

□ Bone Density Test Date ___/___/_____ Normal? □ Yes □ No

□ PSA Date ___/___/_____ Normal? □ Yes □ No

□ History of STD's? □ Yes □ No

□ Testicular Exam Date ___/___/_____ Normal? □ Yes □ No

□ Vasectomy? □ Yes □ No Year _____

□ Cholesterol Date ___/___/_____ Normal? □ Yes □ No

□ Contraception (type) _____

□ Sexual Partners in Lifetime □ < 5 □ > 5 □ > 10

Family History-Please list RELATION and AGE of onset and/or death

ADD/ADHD_____

Alcoholism_____

Allergies _____

Alzheimer's _____

Asthma _____

Blood Disease _____

CAD _____

CAD-Premature _____

Cancer _____

Depression _____

Developmental Delay _____

Diabetes _____

Eczema _____

Hearing Deficiency _____

High Cholesterol _____

High Blood Pressure _____

Name: _____

DOB: _____

Irritable Bowel Disease _____

Learning Disability _____

Mental Illness _____

Migraines _____

Obesity _____

Seizure Disorder _____

Osteoarthritis _____

Stroke _____

PVD _____

Other _____

Renal Disease _____

Hand Dominance Right or Left

Tobacco Use □ Yes □ No □ Former Units/Day _____ Age Started _____

Alcohol Use □ Yes □ No □ Former Frequency _____ Last Drink _____

Illicit Drug Use □ Yes □ No □ Former Frequency _____ Type _____

Caffeine Use □ Yes □ No Type _____ Caffeine / Day _____

Exercise □ Yes □ No Type _____ Hours / Week _____

Animals in Home □ Yes □ No

Recent Travel □ Yes □ No Out of State Out of Country

Dates of travel: _____

Destinations included in travel: _____