Bowmont Medical Clinic

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INITIAL VISIT
PATIENT INFORMATION

Please complete this form and bring it with you to your first appointment, as the information will help to plan your care. Thank You.

Name:	Patient Telephone #	Home:	Date (yy/mm/dd)
	Cell:	Work:	
Occupation:	Email Address:	Emergency Contact:	Referring Physician & Phone #:

FAMILY MEDICAL HISTORY:

Check (✓) if any family member has had the following condition(s) and indicate age, when diagnosed.

		Mother	Father	Sister(s)	Brother(s)	Aunt(s)	Uncle(s)	One or more Grandparent(s)	n/a
☐ Bowel Cancer	Age								
☐ Prostrate Cancer									
☐ Breast Cancer									
☐ Ovarian Cancer									
☐ Heart Attack									
☐ Stroke									
☐ Alzheimer's									

PRESENT FAMILY STATUS:

Check (✓) the following information.

	# of Siblings	Alive	Well	Not Well	Condition	Deceased	Cause(s) of Death
Mother							
Father							
Sister(s)							
Brother(s)							
Children							

PERSONAL MEDICAL HISTORY:

Check (✓) if you have experienced any of the following conditions.

General
☐ Fatigue, enlarged lymph glands
☐ Weight loss/gain

Significant Weight Change
(over last 12 months)
☐ Gain ______________ lbs
☐ Loss ______________ lbs

Head
☐ Headaches
☐ Dizziness

Heart
☐ Heart Disease
☐ Shortness of Breath
☐ Chest Pain (Angina)
☐ Pain in legs/calves when walking
☐ Stroke
☐ High Blood Pressure

Kidneys
☐ Infections

Lungs
☐ Asthma
☐ Emphysema
☐ Tuberculosis

Gastrointestinal
☐ Stomach Pain
☐ Hemorrhoids
☐ Change in Bowel Habits
☐ Constipation
☐ Diarrhea
☐ Stools
☐ Bloody ☐ Black ☐ Painful passing

Obstetrics and Gyne
☐ Pregnancies
☐ Gyne Problems

Mental Health
☐ Depression
☐ Anxiety / Meds
☐ Counselling
☐ Hospitalization, etc.

Liver
☐ Hepatitis
☐ Cirrhosis
☐ Jaundice
☐ Previous Blood Transfusion (year)____
☐ IV Drug Use
☐ Tattoos
☐ HIV
☐ Multiple Sex Partners
☐ Male ☐ Female

Sexual History:

Other
☐ Diabetes
☐ Thyroid Disease
☐ Arthritis
☐ Gout
☐ Cancer
☐ Rashes
☐ Epilepsy/Seizures

	Patient I.D. #

INDICATE YOUR RECENT SURGERIES MOST

Year	Surgical Procedure	Year	Surgical Procedure

INDICATE YOUR MOST RECENT HOSPITALIZATIONS

Year	Medical Problem	Year	Medical Problem

Please list medications you take on a regular basis? (including Birth Control Pills, Laxatives, Aspirin, Inhalers, Hormone Replacement)

Check (✓) if you have any of the following allergies and describe symptoms.

Prescription Medications	Dose	How Often	**Allergies**	**Symptoms**
			☐ Medication(s)	
			☐ Latex	
			☐ Adhesive or Other Tape(s)	
			☐ Foods	
Over the Counter Medications/Herbs/Vitamins	Dose	How Often		
			☐ Other(s)	

Do You Presently: If yes, how much?	**Past History**	**# of years**	**When did you quit?**
Smoke ☐ Yes ☐ No ___________/day	☐ Yes ☐ No		
Drink Alcohol ☐ Yes ☐ No ___________/day	☐ Yes ☐ No		
Drink Coffee, Tea or Cola ☐ Yes ☐ No ___/day	☐ Yes ☐ No		
Drugs ☐ Yes ☐ No ___________/day	TYPES:		

What questions or concerns would you like to discuss at your appointment?

DATE: ___________________________________ **PATIENT SIGNATURE:** ____