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.

Date (yy/mm/dd)	Patient Telephone #	Home:	Family Physician & Phone #:
	Cell:	Work:	
Occupation:	Email Address:		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								
☐ Prostate 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.

G.I.
☐ Stomach Pain
☐ Hemorrhoids
☐ Change in Bowel Habits
☐ Constipation
☐ Diarrhea
☐ Stools
- ☐ Bloody
- ☐ Black
- ☐ Painful when passing

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

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

Heart
☐ Heart Disease
☐ Shortness of Breath
☐ Chest Pain (Angina)

Heart (cont'd)
☐ Pain in legs/calves when walking
☐ Stroke
☐ High Blood Pressure

☐ Asthma
☐ Emphysema
☐ T.B.
☐ Diabetes
☐ Thyroid Disease
☐ Irregular Menstrual Periods

☐ Arthritis
☐ Gout
☐ Cancer
☐ Rashes
☐ Epilepsy/Seizures
☐ Emotional Illness

		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:** _____