Climax Family Practice

1008 NC Highway 62 E

Climax NC 27233

Phone number: 1-336-674-8237

Heather Gibson MSN, FNP-C

Doctor James Little MD

New patient Medical History Form-

Full Name: _____ Date:_____

Birth Date: _____ Age: _____

Allergies NKDA

Allergy	Allergic Reaction

MEDICATIONS: (please bring an updated detailed list of all medications or bring your medications to every visit please!) Include vitamin intake!

Medications (Please List all)	Dose (Mg, Pill etc)	Times taken per day

(if you need more room to list medications, please write them on the back of this form with all required information)

Health Maintenance Screening Test History: Please List facility performed at

Cholesterol	Date:	Facility/Provider	Abnormal Y or N
Colonoscopy	**Date:**	**Facility/provider**	**Abnormal Y or N**

Mammogram	**Date:**	**Facility/provider**	**Abnormal Y or N**
Pap Smear	**Date:**	**Facility/Provider**	**Abnormal Y or N**
Bone Density	**Date:**	**Facility/Provider**	**Abnormal Y or N**

VACCINATION HISTORY:

Last Tetanus Booster Tdap:		
Last Flu Vaccine:	**Last Zoster Vaccine (Shingles)**	
Last Prevnar:		

Personal Medical History: This is YOUR health!

Disease/Condition	Current	Past	Comments
Alcoholism/Drug Abuse			
Asthma			
Cancer (type)			
Depression Anxiety Bipolar Suicidal/homicidal			
Diabetes (type)			
Emphysema COPD			
Heart Disease			
High Blood pressure			
High Cholesterol			
Renal (kidney disease)			
Migraine Headaches			
Stroke			
Other:			
Other:			

Other:			

Surgeries:

Type: Specify right /left	**Date:**

Womens Health History

Date of last Menstrual Cycle:	**Age of First Menstruation:** **Age of first sexual encounter:** **Age of menopause:**
Total Number of Pregnancies:	**Live Births:**
Pregnancy complications:	**Pregnancy Complications:**

Patient Name_____ Date:_____

Family Medical history

Please check all that apply in the appropriate boxes:

Check all that apply	**Alcohol/Drug abuse**	**Asthma**	**Cancer Type:**	**COPD**	**Depression Anxiety Bipolar**	**Diabetes**	**Early Death**
Mother							
Father							
Brother							

Sister							

CHECK	**Heart Disease**	**High Cholesterol**	**High BP**	**Kidney disease**	**Stroke**	**Thyroid**	**Migraines**
Father							
Mother							
Brother							
Sister							

Social History:

Occupation: (or-prior)	**Retired Unemployed LOA Disabled**
Employer:	**Years of education/highest degree:**
Do you work night shift?	**Marital Status Single Partner Married Divorced Widowed Other**
Do you have children?	**If Yes? How Many?**

Other Health Issues:

Tobacco: Smoke? Y or N **Smokeless Tobacco? Y or N?** **Vape? Y or No?** **Chew? Y or No?**	**Current: packs Per day____# of years_____** **Past: Quit Date:_____Packs Per day___# of years_____**
Alcohol Drug Use: do you drink? Y or N?	**Beer wine Liquor # of drinks per week___/day___**
Do you use marijuana or recreational drugs?	**Have you ever taken someone else's drugs?**
Have you ever used needles to inject drugs?	

Sexual Activity:

Sexually involved currently Y or N	**Sexual partners is/are/have been: male or female?**
Birth control method None-Condom-pill/ring/patch/inj/iud vasectomy	**Exercise: do you exercise regularly? Y or N**
What type of exercise? Duration? How often?	**How many hours on average do you slep at night?**

How would you rate your diet? Good Poor Fair	**Would you like advice on your ediet?**
Do you use a bike helmet?	**Do you use seat belts consistently?**
Working smoke detector in home?	**If you have guns at home are they locked up?**
Is violence at home a concern for you?	**Have you completed an advanced directive for health care a living will, or physical orders for life sustaining therapy?**

Other Provider/Specialist

Specialist	**Name**	**Last Visit**
Cardiology		
Gastroenterologist		
OB/GYN		
Neurology		
Pulmonary		
Other:		
Other:		

Additional Information:

Have you traveled outside of the country in the last 30 days? Y or N if Y where?

Are you planning to travel outside of the country in the next 30 days? Y or N- please let us know to keep you up to date on any travel information you may need to know!

Have you served in the military? Y or N If yes? How long and what branch?

Were you deployed? Y or N If Yes where?

Constitution	**Cardiovascular**	**SKIN**
Activity Change	Chest pain	Color changes
Activity Change	Leg Swelling	Pallor (paleness)
Chills	Palpitations	rash
Diaphoresis	**Gastrointestinal**	wound
Fatigue	Abdominal distention	Moles of concern

Fever	Abdominal pain	**ALLERGY/IMMUNO**
Unexpected weight change	Anal bleeding	Environmental allergies Food allergies Immunocompromised
HEAD EAR NOSE THROAT	Blood in stool	**NEUROLOGICAL**
Congestion	**c**onstipation	Dizzy
Dental Problem	Diarrhea	Facial Asymmetry
Drooling	Nausea	Headaches
Ear Discharge	Rectal pain	Light-Headedness
Ear Pain	Vomiting	Numbness
Facial Swelling	**ENDOCRINE**	Seizures
Hearing Loss	Cold intolerance	Speech difficulty
Mouth Sores	Heat Intolerance	Syncope
Nosebleeds	Increased thirst	Tremors
Postnasal Drip	Excessive hunger	weakness
Rhinorrhea (runny nose)	Excessive urination at night	**HEMATOLOGIC**
Sinus Pressure	**GENITOURINARY**	Lymph node swelling
Sneezing	Difficult urination	Bruise bleed easily
Sore throat	Painful urination	**PSYCHIATRIC**
Tinnitus (ringing of the ears)	Nighttime bed wetting	Agitation
Trouble Swallowing	flank pain	Behavior problem
Voice changes	Frequency	confusion
EYES	Genital sore	Decreased concentration
Eye Discharge	Hematuria	Dysphonic mood
Eye Itching	Penile discharge	Hallucinations
Eye Pain	Scrotal pain	hyperactive
Eye Redness	Testicular pain	Nervous/anxiety
Photophobia	Urgency	Self injury
Visual Disturbances	Urine Decreased	Sleep disturbance

RESPIRATORY	**MUSCULAR:**	Suicidal or homicidal idea
Apnea	Joint pain	
Chest Tightness	Back pain	
Choking	Gait problems	
Cough	Joint swelling	
Shortness of breath	Muscle pain	
Stridor (high pitch noise on breathing)	Neck pain	
Wheezing	Neck stiffness	