Cooley Dickinson Medical Group
Northampton Family Medicine

All established PEs

Established Patient Health History

CDMG 2050 10/16

Name: _____DOB: _____/_____/_____ Date: _____/_____/_____

Please list any concerns you would like to discuss with the provider: _____

_____

Since your last visit:

Have you had any surgeries or hospitalizations? Yes No

Have you developed any new medical problems or concerns? Yes No

Has there been a change in your family history? Yes No

Have you developed any new allergies to medications, foods, or insects? Yes No

If you answered yes to any of the above, please provide details below:

_____

_____

Have you started any new medications since your last visit (Prescriptions, vitamins, over-the-counter)?

_____

When was your last eye exam? _____

When was your last colonoscopy: _____

Do you need any medication refills today? Yes No

Please circle any of the following that you have experienced:

Weight Gain Weight Loss Swollen Glands Weakness Headaches Seizures or Convulsions

Nose Bleed(s) Blurred Vision Double Vision Eye Pain Red Eye Decreased Vision Ear Pain Hearing Difficulties

Ringing in Ears Sore Throat Allergies Nose Congestion Itchy Eyes Hoarse Voice Canker Sore Dental Problem

Falls Fainting Dizziness Leg Ache After Walking Varicose Veins Swelling in Ankles or Feet Shortness of Breath

Chest Pain or Discomfort Heart Skipping Beats Heart Racing Cough Coughing Up Blood or Phlegm Wheezing

Trouble Swallowing Heartburn or Indigestion Stomach Pain Vomiting Gas Blood in Bowel Movement Diarrhea

Constipation Change in Stool Color Frequent Urination Painful Urination Blood in Urine Trouble Starting Urine

Urinary Dribbling Loss of Control of Urine Sexual Issues/Concerns

Nervousness Depression Nightmares Sleep Difficulties

Painful/Aching/Stiff Joints Back Pain Leg Cramps Pinched Nerve Numbness/Tingling in Extremities

<u>For Men:</u> Sore on Penis Lump in Testicle Drainage from Penis Erectile Dysfunction

Other: _____

<u>For Women:</u> Irregular Periods Lump in Breast Nipple Discharge Painful Periods Menopause

Start of last menstrual period or post-menopausal: _____

When was your last GYN exam? _____ When was your last mammogram? _____