CENTRAL COAST FAMILY CARE
MEDICAL ASSOCIATES OF SANTA MARIA, INC.

NEW PATEINT WORKSHEET

Patient Name: _____ _____ _____ _____ _____ _____ Date: _____ _____ _____

FAMILY HISTORY:

If any of the following run in your family, mark with an X on the appropriate item.

_____Allergies _____Cancer _____Tuberculosis _____Diabetes _____Heart Disease _____Stroke

Father Age _____ _____Alive _____Deceased
Medical Conditions: _____

Mother Age _____ _____Alive _____Deceased
Medical Conditions: _____

Sibling: Brother/Sister Age _____ _____Alive _____Deceased
Medical Conditions: _____

Sibling: Brother/Sister Age _____ _____Alive _____Deceased
Medical Conditions: _____

Sibling: Brother/Sister Age _____ _____Alive _____Deceased
Medical Conditions: _____

Child: Male/Female Age _____ _____Alive _____Deceased
Medical Conditions: _____

Child: Male/Female Age _____ _____Alive _____Deceased
Medical Conditions: _____

Child: Male/Female Age _____ _____Alive _____Deceased
Medical Conditions: _____

REVIEW OF SYMPTONS: Place a mark an X in the appropriate line if you are experiencing any of the following symptoms

HEAD AND NECK:

_____ Severe Headaches?
_____ Dizzy Spells?
_____ Failing Vision?
_____ Eye Pain?
_____ Double Vision?
_____ See Floating lights
_____ Severe Hearing Loss?
_____ Ringing in Ears?
_____ Pain in Ears?
_____ Discharge from Ears?
_____Repeated Nosebleeds?
_____ Other
_____ Chronic Nose Obstruction?
_____ Chronic Sore Tongue?
_____ Persistent Sore Gums?
_____ Prolonged Hoarseness?
_____ Swelling in Neck?

HEART AND LUNGS:

_____ Chest Pain on effort?
_____ Skipping Heart Beats?
_____ Difficulty Breathing?
_____ Sit up to Breathe easy?
_____ Have Chronic Cough?
_____ Spit up Blood?
_____ Chronic Nose Obstruction?
_____ Ankles Swell?
_____ Any Heart Defects?

STOMACH AND INTESTINES:

_____ Chronic Abdominal Pain?
_____ Persistent Nausea?
_____ Heartburn?
_____ Appetite Loss?
_____ Vomit Blood?
_____ Skin Turn Yellow?
_____ Any Chronic Diarrhea?
_____ Any Black, Tarry Stools?
_____ Any Blood in Rectum?
_____ Constipation?
_____ Have Hemorrhoids?

URINARY TRACT, ETC:

_____ Any Excess Urination?
_____ Any Difficulty Urinating?
_____ Scanty Urination?
_____ Any blood in Urine?
_____ Excess Night Urination?
_____ Pain with Urination?
_____ Date of last Menstrual Period _____ _____ _____
_____ Any Leakage of Urine?
_____ Passed any Stones?
_____ Any Bed-wetting?
_____ Any Retention of Urine
_____ Pain with Urination?
_____ Painful Menstruation?

(For Women Only)

_____ Excess Menstruation
_____ Bleed Between periods
_____ Any Missed periods?
_____ Number of Pregnancies
_____ Number of living Children
_____ Age of Menopause

MUSCLES- JOINTS-NERVES:

_____ Any Tingling Sensations?
_____ Any Numbness?
_____ Disturbance in Walking?
_____ Any Paralysis?
_____ Any Shaking?
_____ Personality Changes?
_____ Any Limited Motions?
_____ Any Joint Trouble?
_____ Nervous Breakdown?
_____ Any Strokes
_____ Any Memory Loss?
_____ Any Varicose Veins?
_____ Speech Disturbances?
_____ Any Seizures?
_____ Any Alcohol Problem?
_____ Any Drug Problems?
_____ Any Mental Problem?

Patient Name: _____

Today's Date: _____

CENTRAL COAST FAMILY CARE
MEDICAL ASSOCIATES OF SANTA MARIA, INC.

REFERRAL: Who referred you to our office?

CHIEF COMPLAINT: Please describe the purpose of your visit today?

MEDICAL HISTORY: List any diseases or medical conditions:

PAST SURGERIES: None or list any past surgeries with approximate date performed:

ALLERGIES: None or list any allergies to medications, foods, adhesives, or other

---

ACCIDENTS: List any serious type injuries, with approximate age

---

SOCIAL HISTORY:

What is your Marital Status? _____Married _____Single _____Divorced _____Widowed _____Separated

What type of work do you do? _____

Do you smoke? _____Never _____Quit (_____ Packs per Day x _____ Years) _____Smokes (_____ Packs per Day x _____ Years)

Do you drink alcohol (ETOH)? ____ Never ____Rarely ____ Occasionally ____ Daily ____Drinks per day ____ Drinks per week

Exercise Level: _____Never _____ Light _____Moderate _____ Heavy

Diet? _____ No Restrictions _____ Low Salt _____Low Cholesterol _____ Low Fat _____

Other _____ _____ _____ _____ _____