Wake Forest®
Baptist Health
Wake Forest Health Network

PATIENT INFORMATION

Full Name:	Address:
Birth Date:	City:
Age:	State: Zip:
Sex: ❑ Male ❑ Female	Primary Phone:
SSN#:	Work Phone:
Employment Status:	Mobile Phone:
Employer:	Secondary Phone:
Retirement Date *(if applicable)*:	Email:
Marital Status: ***Please Check One*** ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Legally Separated ❑ Domestic Partner	Race: ***Please Check One*** ❑ American Indian or Alaskan Native ❑ Asian ❑ Black or African American ❑ Other Pacific Islander ❑ Unknown/Other Race ❑ White or Caucasian
Ethnicity: ***Please Check One*** ❑ Hispanic or Latino ❑ Non-Hispanic or Latino ❑ Unknown	Emergency Contact: Emergency Number: Relationship of Emergency Contact:
Preferred Language:	
If Patient is a MINOR: ***Please Complete this Section***	
Mother's Name:	Father's Name
Mother's Birthdate:	Father's Birthdate:
Mother's Phone:	Father's Phone:
Is Mother the Guarantor? Y N	Is Father the Guarantor? Y N

INSURANCE INFORMATION

PRIMARY INSURANCE	**SECONDARY INSURANCE**
Member Number/ID for Patient:	Member Number/ID for Patient:

Wake Forest®
Baptist Health
Wake Forest Health Network

Group Number:	Group Number:
Group Name:	Group Name:
Subscriber Name *(name on card)*:	Subscriber Name *(name on card)*:
Subscriber Birthdate:	Subscriber Birthdate:
Relationship to Patient:	Relationship to Patient:

NEW PATIENT
MEDICAL HISTORY FORM

Full Name: _____ Date: _____

Birth Date: _____ Age: _____

ALLERGIES ❑ NO ALLERGIES

ALLERGY	ALLERGIC REACTION

MEDICATIONS

MEDICATIONS *(Please list ALL)*	DOSE *(Mg., pill, etc.)*	TIMES PER DAY

If you need more room to list medications, please write them on a blank sheet of paper with the required information

Wake Forest Baptist Health
Wake Forest Health Network

PERSONAL MEDICAL HISTORY

DISEASE/CONDITION	CURRENT	PAST	COMMENTS
Alcoholism/Drug Abuse			
Asthma			
Cancer *(type:_____)*			
Depression/Anxiety/Bipolar/Suicidal			
Diabetes *(type:_____)*			
Emphysema *(COPD)*			
Heart Disease			
High Blood Pressure *(hypertension)*			
High Cholesterol			
Hypothyroidism/Thyroid Disease			
Renal *(kidney)* Disease			
Migraine Headaches			
Stroke			
Other:			
Other:			

SURGERIES

TYPE *(specify left/right)*	DATE	LOCATION/FACILITY

Patient Name: _____ DOB: _____

Wake Forest Baptist Health
Wake Forest Health Network

FAMILY MEDICAL HISTORY ❑ NO SIGNIFICANT FAMILY HISTORY IS KNOWN

✓ CHECK ALL THAT APPLY	Alcohol/DrugAbuse	Asthma	Cancer (type:_____)	Emphysema(COPD)	Depression/Anxiety	Bipolar	Suicide	Early Death	HeartDisease	HighCholesterol	HighBlood Pressure	KidneyDisease	Stroke	ThyroidDisease	Migraines	Diabetes	Other_____	Other_____
Mother																		
Father																		
Brother																		
Sister																		
Child																		
MGM																		
MGF																		
PGM																		
PGF																		
Other:_____																		

SOCIAL HISTORY

Occupation *(or prior occupation)*:	❑ Retired ❑ Unemployed ❑ LOA ❑ Disabled
Employer:	Years of Education or Highest Degree:
If employed, do you work the night shift? Y N N/A	
Marital Status *(check one)*: ❑ Single ❑ Partner ❑ Married ❑ Divorced ❑ Widowed ❑ Other:_____	
Do you have children? Y N	If yes, how many?

Patient Name: _____ DOB: _____

Wake Forest Baptist Health
Wake Forest Health Network

OTHER HEALTH ISSUES

TOBACCO USE	Smoke Cigarettes? Y N *(If you never smoked, please move to Alcohol /Drug Use)*		
Current: Packs/day _____ # of Years _____	***Past:*** Quit Date: _____ Packs/day _____ # of Years _____		
Other Tobacco *(check one)*: ❑ Pipe ❑ Cigar ❑ Snuff ❑ Chew			
ALCOHOL/DRUG USE	Do you drink alcohol? Y N	❑ Beer ❑ Wine ❑ Liquor	# of Drinks/week:
Do you use marijuana or recreational drugs? Y N		Have you ever used needles to inject drugs? Y N	
Have you ever taken someone else's drugs? Y N			

OTHER HEALTH ISSUES continued…

SEXUAL ACTIVITY	Sexually involved currently? Y N *(If no sexual history, please continue to Exercise)*
Sexual partner(s) is/are/have been: ❑ Male ❑ Female	
Birth control method: ❑ None ❑ Condom ❑ Pill/Ring/Patch/Inj/IUD ❑ Vasectomy	

ADDITIONAL INFORMATION

Have you traveled outside of the country in the last 30 days? Y N	If yes, where?
Have you served in the military? Y N	If yes, how long and what branch?
Were you deployed? Y N	If yes, where?

REVIEW OF SYSTEMS ✓ CHECK ALL THAT APPLY

	CONSTITUTION		CARDIOVASCULAR		SKIN
	Activity change		Chest pain		Color change
	Appetite change		Leg swelling		Pallor
	Chills		Palpitations		Rash

Patient Name: _____ DOB: _____

Wake Forest® Baptist Health
Wake Forest Health Network

	Diaphoresis		**Gastrointestinal**		Wound
	Fatigue		Abdominal distention		**ALLERGY/IMMUNO**
	Fever		Abdominal pain		Environmental allergies
	Unexpected weight change		Anal bleeding		Food allergies
	HEAD, EAR, NOSE & THROAT		Blood in stool		Immunocompromised
	Congestion		Constipation		**NEUROLOGICAL**
	Dental problem		Diarrhea		Dizziness
	Drooling		Nausea		Facial asymmetry
	Ear discharge		Rectal pain		Headaches
	Ear pain		Vomiting		Light-headedness
	Facial swelling		**ENDOCRINE**		Numbness
	Hearing loss		Cold intolerance		Seizures
	Mouth sores		Heat intolerance		Speech difficulty
	Nosebleeds		Polydipsia		Syncope
	Postnasal drip		Polyphagia		Tremors
	Rhinorrhea		Polyuria		Weakness
	Sinus pressure		**Genitourinary**		**HEMATOLOGIC**
	Sneezing		Difficulty urinating		Adenopathy
	Sore throat		Dysuria		Bruises/bleeds easily
	Tinnitus		Enuresis		**PSYCHIATRIC**
	Trouble swallowing		Flank pain		Agitation
	Voice change		Frequency		Behavior problem
	EYES		Genital sore		Confusion
	Eye discharge		Hematuria		Decreased concentration
	Eye itching		Penile discharge		Dysphoric mood
	Eye pain		Penile pain		Hallucinations
	Eye redness		Penile swelling		Hyperactive
	Photophobia		Scrotal swelling		Nervous/anxious
	Visual disturbance		Testicular pain		Self-injury
	RESPIRATORY		Urgency		Sleep disturbance
	Apnea		Urine decreased		Suicidal ideas
	Chest tightness		**MUSCULAR**		
	Choking		Arthralgias		
	Cough		Back pain		
	Shortness of breath		Gait problems		
	Stridor		Joint swelling		
	Wheezing		Myalgias		
			Neck pain		
			Neck stiffness		

Patient Name: _____ DOB: _____