Jacksonville office:
2593 Henderson Drive Ext.
Jacksonville, NC 28546
Tel.: 910-577-ENDO (3636)

Kinston Office & Endoscopy Center:
2541 N Queens Street
Kinston, NC 28501
Tel.: 252-527-ENDO (3636)

NEW PATIENT HISTORY FORM

Name_____ **Sex: ☐F ☐M** **DOB**_____ **Age**_____ **Date**_____
Marital status: Single_____ Married____ Divorced____ Widowed_____ Number of Children_____
Primary Care Physician_____

It is important for our physicians / PAC to have your complete health history. Please help us by taking the time to provide this information accurately and completely. This information will be a confidential part of your medical record.

PAST SURGICAL AND MEDICAL HISTORY—(Circle Yes or NO) If yes, Date of onset, comments.

MEDICAL HISTORY	YES	NO	Onset, Comments	SURGICAL HISTORY	YES	NO	Date, Comments
Anorexia / Bulemia	Yes	No		Colon	Yes	No	
Arthritis / Joint swelling	Yes	No		Stomach	Yes	No	
Asthma	Yes	No		**Heart:**	Yes	No	
Bleeding disorder	Yes	No		Stent / Bypass	Yes	No	
Blood or infectious disease	Yes	No		Valve	Yes	No	
Cancer, Type:	Yes	No		Pacemaker	Yes	No	
Colon polyps	Yes	No		Defibrillator	Yes	No	
Crohn's disease	Yes	No		Joint replacement	Yes	No	
Diabetes	Yes	No		Gallbladder	Yes	No	
Epilepsy / seizures	Yes	No		Hysterectomy	Yes	No	
Gallstones	Yes	No		Appendix	Yes	No	
Glaucoma	Yes	No		Prostate	Yes	No	
Headaches/ fainting/ dizziness	Yes	No		Bladder	Yes	No	
Heart problems/ Chest pain	Yes	No		C-section	Yes	No	
Hepatitis / Liver problems	Yes	No		Breast	Yes	No	
Hiatal hernia / GERD	Yes	No		Other surgeries			
High / low Blood pressure	Yes	No		Other surgeries			
Kidney disease	Yes	No		Other surgeries			
Lung Disease	Yes	No		Other surgeries			
Pacemaker / Internal defibrillator	Yes	No		Anesthesia Problems	Yes	No	
Sleep Apnea	Yes	No		Previous EGD	Yes	No	
Stomach problems / ulcers	Yes	No		Prev Colonoscopy	Yes	No	
Stroke	Yes	No		**Vaccinations (yes or No, and date)**			
Thyroid problems	Yes	No		Hepatitis A	Yes	No	
Tuberculosis	Yes	No		Hepatitis B	Yes	No	
Ulcerative Colitis	Yes	No					

Other

CURRENT MEDICATIONS: Please include vitamins, herbs, and pain relievers **AND RECENT ANTIBIOTICS**

Medication	Dosage	Times per day	Medication	Dosage	Times per day

ALLERGIES	REACTION	ALLERGIES	REACTION	ALLERGIES	REACTION

ATLANTIC MEDICAL GROUP, PC

New Patient History Form (Continued)

Name_____ **Sex:** ☐**F** ☐**M** **DOB**_____ **Age**_____ **Date**_____

SOCIAL HISTORY: (Past or Current)				
Alcohol	Yes	No	Quit	Duration & Amount
Coffee / Caffeine	Yes	No	Quit	Duration & Amount
Substance Abuse	Yes	No	Quit	Duration & Amount
Tobacco	Yes	No	Quit	Duration & Amount
Blood Transfusions	Yes	No	When?	
Tattoos	Yes	No		
Do you exercise?	Yes	No	How much?	
FAMILY HISTORY: Please indicate any **RELATIVES** with the following diseases.				
Alcoholism	Yes	No		
Cirrhosis / Jaundice	Yes	No		
Colon Cancer	Yes	No		
Colon or rectal polyps	Yes	No		
Crohn's/Ulcerative Colitis	Yes	No		
Diabetes	Yes	No		
Gallstones	Yes	No		
Hemachromatosis	Yes	No		
Heart disease	Yes	No		
High Blood Pressure	Yes	No		
Liver Disease	Yes	No		

SYMPTOM REVIEW Check (☒) symptoms you currently have or have had in the past

☐ Weight Loss	☐ Cough	☐ Frequent urination	☐ Memory loss
☐ Fever/Chills	☐ Shortness of breath	☐ Incontinence of urine	☐ Depression
☐ Poor vision/double vision	☐ Heart burn	☐ Difficulty urinating	☐ Anxiety
☐ Dry mouth	☐ Nausea / vomiting	☐ Blood in urine	☐ Hair loss
☐ Frequent nosebleeds	☐ Swallowing difficulties	☐ Arthritis/Joint pain	☐ Hot/Cold sensitivity
☐ Hearing loss	☐ Pain with swallowing	☐ Muscle aches	☐ Excessive thirst
☐ Nasal congestion	☐ Abdominal pain	☐ New or chronic rash	☐ Easy bruising
☐ Hoarseness	☐ Diarrhea	☐ Nail changes	☐ Excessive bleeding
☐ Chest pain	☐ Constipation	☐ Headaches	☐ Swollen lymph nodes
☐ Irregular heart beat	☐ Blood in stool	☐ Seizures	☐ Swelling of ankles/legs

Other:

REVIEWED BY: **DATE:**

If this form was filled out more than 30 days ago patient and physician will review and update:

Patient Signature: *Physician signature:* *Date:* ☐ *No changes* ☐ *Changes made.*

Patient Signature: *Physician signature:* *Date:* ☐ *No changes* ☐ *Changes made.*

Physician / PAC Signature

Jacksonville Office:
2593 Henderson Drive Ext.
Jacksonville, NC 28546
Tel: 910-577-3636

Kinston Office:
2541 N .Queen Street
Kinston NC 28501
Tel: 252-527-3636

PATIENT DEMOGRAPHICS

Patient Name: _____

Patient Address: _____ City_____State_____Zipcode_____

Patient Date of Birth: _____ Patient Social Security Number: _____-_____-_____

Patient Phone Number: _____ Alternate Phone Number: _____

INSURANCE INFORMATION

Primary Insurance: _____

Policy Number:_____ Group Number:_____

Name of Policy Holder (as it appears on card):_____

Policy Holder Date of Birth: _____ Policy Holder SSN: _____-_____-_____

Secondary Insurance:_____

Policy Number:_____ Group Number:_____

Name of Policy Holder (as it appears on card):_____

Policy Holder Date of Birth: _____ Policy Holder SSN: _____-_____-_____

Other Insurance:_____

Policy Number:_____ Group Number:_____

Name of Policy Holder (as it appears on card):_____

Policy Holder Date of Birth: _____ Policy Holder SSN: _____-_____-_____

Patient Signature:_____ Date:_____