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Board Certified Family Medicine



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**NEW PATIENT MEDICAL HISTORY AND QUESTIONNAIRE**

*The information on this form is part of your confidential medical record. Please be honest with your responses. Please be advised that, for identification and part of your medical record, your photograph will be taken during your first visit.*

Name: \_\_\_\_\_ Male / Female Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_  
Address: \_\_\_\_\_ Social Security Number: \_\_\_\_ - \_\_\_\_ - \_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Home Phone: \_\_\_\_\_  
**EMAIL ADDRESS:** \_\_\_\_\_ Cell Phone: \_\_\_\_\_

**EMERGENCY CONTACT:**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

I hereby  DO or  DO NOT give permission to leave messages on my answering machine regarding appointment reminders, results of blood work, or results of other studies.

I hereby  DO or  DO NOT give permission to receive email regarding appointment reminders, results of blood work, or results of other studies.

I hereby give permission to Lehigh Family Medicine to discuss my medical issues, lab results, or any other matters related to my health with ONLY the following persons: (maximum of two)

1. \_\_\_\_\_  2. \_\_\_\_\_

**None.** I expressly want my medical issues to remain completely private and not discussed with any family members.

**EMPLOYER (or NAME OF SCHOOL):**

Employer: \_\_\_\_\_  
Location: \_\_\_\_\_  
Occupation: \_\_\_\_\_  
Work Phone: \_\_\_\_\_

**ADDITIONAL HOUSEHOLD MEMBERS:**

Name: \_\_\_\_\_ Age: \_\_\_\_\_  
Name: \_\_\_\_\_ Age: \_\_\_\_\_  
Name: \_\_\_\_\_ Age: \_\_\_\_\_  
Name: \_\_\_\_\_ Age: \_\_\_\_\_  
Name: \_\_\_\_\_ Age: \_\_\_\_\_

**PREVIOUS PHYSICIAN or MEDICAL GROUP:** \_\_\_\_\_

How did you find us:  Previous Patient  Phone Book  Internet  Friend: \_\_\_\_\_

**PREFERRED LOCAL PHARMACY:** \_\_\_\_\_ City: \_\_\_\_\_

For long term medication, I prefer to use a mail order pharmacy:

**MAIL ORDER PHARMACY:** \_\_\_\_\_ FAX #: \_\_\_\_\_

**INSURANCE INFORMATION:**

Primary Insurance Co: \_\_\_\_\_

Name of Insured: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Subscriber ID: \_\_\_\_\_ Group Number: \_\_\_\_\_

Secondary Insurance Co: \_\_\_\_\_

Name of Insured: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Subscriber ID: \_\_\_\_\_ Group Number: \_\_\_\_\_

Other:  Self Pay (no insurance)  Workman's Compensation

**MEDICAL HISTORY:** (Please check *only those that apply to YOU.*)

**NOW PAST Unsure**

- High Blood Pressure
- Diabetes (without insulin)
- Diabetes (with insulin)
- High Cholesterol
- Obesity

**NOW PAST Unsure**

- Esophageal reflux (GERD)
- Stomach ulcer
- Jaundice or liver disease
- Crohn's or Colitis
- Diverticular disease

- Heart Attack
- Heart Valve Disease
- Palpitations
- Congestive Heart Failure (CHF)
- Chronic chest pain

- Kidney disease
- Skin disease
- Thyroid problems
- Difficulty urinating
- Bleeding problems

- Asthma
- COPD / Emphysema
- History of pneumonia
- History of tuberculosis
- Chronic cough

- Arthritis
- Chronic back pain
- Chronic infections
- Anemia
- Gout

- Epilepsy / Seizures
- Stroke or TIA
- Migraines / Headaches
- Anorexia or bulimia
- Dizziness

- Alcohol abuse
- Substance abuse
- Depression
- Anxiety disorder
- Bipolar disorder

**PAST SURGICAL HISTORY:      YEAR OF SURGERY:**

- Ear tube placement ..... \_\_\_\_\_
- Tonsillectomy & Adenoidectomy ..... \_\_\_\_\_
- Appendectomy ..... \_\_\_\_\_
- Gall bladder removal ..... \_\_\_\_\_
- Hysterectomy ..... \_\_\_\_\_
- Mastectomy of Left or Right breast... \_\_\_\_\_
- Nephrectomy of Left or Right kidney. \_\_\_\_\_
- Prostatectomy ..... \_\_\_\_\_
- Coronary Angioplasty ..... \_\_\_\_\_
- Coronary Artery Stent Placement ..... \_\_\_\_\_
- Coronary Artery Bypass ..... \_\_\_\_\_
- Other surgery: \_\_\_\_\_
- Other surgery: \_\_\_\_\_

**PAST CANCER HISTORY:**

- No known history of any cancer
- Cancer of: \_\_\_\_\_ year: \_\_\_\_\_
  - History of chemotherapy
  - History of radiation therapy
  - Cured or in remission
  - Continuing with treatment at this time
- Cancer of: \_\_\_\_\_ year: \_\_\_\_\_
  - History of chemotherapy
  - History of radiation therapy
  - Cured or in remission
  - Continuing with treatment at this time
- Other: \_\_\_\_\_
- Other: \_\_\_\_\_

**SOCIAL HISTORY:**

Marital status: Single Married Divorced Widowed Under age of 17, living with parent/guardian  
Living situation: Living alone Living with spouse Living with children #\_\_\_ other: \_\_\_\_\_  
Tobacco use: Never smoked Former smoker, quit \_\_\_ years ago Currently smoking for \_\_\_ total years  
Alcohol use: None Socially Frequently: \_\_\_ drinks/beers per day In active recovery  
Recreational drug use: None Former user of... Active user of... Marijuana Cocaine Opiates

**FAMILY MEDICAL HISTORY:**

Mother Living, age \_\_\_ Deceased at age \_\_\_ due to: \_\_\_\_\_  
History of: Hypertension Diabetes Heart disease Other: \_\_\_\_\_ Cancer: \_\_\_\_\_  
Father Living, age \_\_\_ Deceased at age \_\_\_ due to: \_\_\_\_\_  
History of: Hypertension Diabetes Heart disease Other: \_\_\_\_\_ Cancer: \_\_\_\_\_  
Siblings: None #\_\_\_ brothers, #\_\_\_ sisters  
History of: Hypertension Diabetes Heart disease Other: \_\_\_\_\_ Cancer: \_\_\_\_\_  
Other family history: \_\_\_\_\_

