



Community Medical Associates

Daniel Miller, MD · Douglas Sposetta, APRN-CNP, FNP-BC

1450 S. Canfield-Niles Rd., Austintown, OH 44515

Phone (330) 799-8752 · Fax (330) 799-8754

NEW PATIENT HEALTH HISTORY

Please complete before your visit. Print clearly. A parent or legal guardian completes this form if the patient is under 18. Bring a photo ID and a current medicine list. Address, phone, email, pharmacy, emergency contact, and Social Security number are on the registration page.

Patient legal name _____ Date of birth _____ Age _____

Preferred name _____ Preferred provider, if any _____

1. Today's visit

☐ New to the practice ☐ Transfer of care

Main reason for today's visit _____

Other concerns you would like addressed _____

2. Allergies

Medicines, foods, latex, contrast, bees, or other. Include the reaction.

☐ No known allergies

Allergen	What happens (rash, swelling, trouble breathing, nausea)	Severe?
_____	_____	☐ Yes ☐ No
_____	_____	☐ Yes ☐ No
_____	_____	☐ Yes ☐ No
_____	_____	☐ Yes ☐ No

3. Current medicines

Prescriptions, over-the-counter medicines, vitamins, herbs, and injections.

☐ I take no medicines or supplements ☐ I brought my bottles or a printed list

Name	Dose	How often	Reason	Prescriber
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

4. Specialists you see now

Name	Specialty	City or phone
_____	_____	_____
_____	_____	_____
_____	_____	_____



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5. Past medical history — check any condition you have now or have had

- | | | | |
|--|---|---|--|
| ☐ High blood pressure | ☐ High cholesterol | ☐ Diabetes / prediabetes | ☐ Thyroid problem |
| ☐ Heart attack | ☐ Heart failure | ☐ Atrial fibrillation | ☐ Heart stent or bypass |
| ☐ Pacemaker / defibrillator | ☐ Stroke / TIA | ☐ Blood clot (leg or lung) | ☐ Anemia |
| ☐ Bleeding or clotting disorder | ☐ Blood transfusion | ☐ Asthma | ☐ COPD / emphysema |
| ☐ Sleep apnea | ☐ Seasonal allergies | ☐ Tuberculosis | ☐ GERD / reflux |
| ☐ Stomach ulcer | ☐ Gallbladder disease | ☐ IBD / IBS / colitis | ☐ Liver disease / hepatitis |
| ☐ Kidney disease | ☐ Kidney stones | ☐ Frequent UTIs | ☐ Prostate problem |
| ☐ Migraines | ☐ Seizures | ☐ Neuropathy | ☐ Parkinson's / tremor |
| ☐ Arthritis | ☐ Osteoporosis | ☐ Gout | ☐ Fibromyalgia / chronic pain |
| ☐ Chronic back or neck pain | ☐ Depression | ☐ Anxiety | ☐ Bipolar disorder |
| ☐ ADHD | ☐ PTSD | ☐ Cancer — type: _____ | ☐ HIV |
| ☐ Autoimmune (lupus, RA) | ☐ Glaucoma / eye disease | ☐ Hearing loss | ☐ Obesity |

Other conditions not listed _____

6. Surgeries, procedures, and hospital stays

☐ None

Surgery, procedure, or reason for the stay	Year	Hospital / location

7. Family history

Check the box under each blood relative who has had the condition. For cancer, write the type. If you were adopted or do not know a side of the family, check the box below.

Condition	Mother	Father	Sibling	Child	Grandparent
High blood pressure	☐	☐	☐	☐	☐
Heart disease or heart attack before age 60	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐
High cholesterol	☐	☐	☐	☐	☐
Cancer — type:	☐	☐	☐	☐	☐
Thyroid disease	☐	☐	☐	☐	☐
Kidney disease	☐	☐	☐	☐	☐
Asthma or other lung disease	☐	☐	☐	☐	☐
Blood clot or bleeding problem	☐	☐	☐	☐	☐
Depression, suicide, or other mental illness	☐	☐	☐	☐	☐
Alcohol or drug problems	☐	☐	☐	☐	☐
Alzheimer's disease or dementia	☐	☐	☐	☐	☐
Sudden unexplained death	☐	☐	☐	☐	☐

☐ Adopted / family history unknown

☐ No significant family history that I know of

Other family conditions _____



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8. Social history

Occupation / school / grade _____ Employer / school name _____

Living situation

☐ House ☐ Apartment ☐ With family ☐ Alone ☐ Assisted living ☐ Unstable / other

Who lives with you? _____ Children in the home — ages _____

Tobacco and vaping

☐ Never ☐ Former — quit year _____ ☐ Current cigarettes ☐ Cigars / pipe ☐ Vape

☐ Chew / dip Packs per day ____ Years smoked ____ ☐ Interested in quitting ☐ Secondhand smoke

Alcohol

☐ None Drinks per week ____ What do you usually drink? _____

Six or more drinks in one sitting ☐ Never ☐ Monthly ☐ Weekly or more ☐ I should cut down

Other substances

☐ None ☐ Marijuana / THC ☐ CBD ☐ Cocaine ☐ Meth / stimulants ☐ Heroin / fentanyl / other opioids

☐ Misuse of prescription medicine ☐ In recovery ☐ Interested in help

Other / how often _____

Sexual history

Sex partners ☐ Men ☐ Women ☐ Both ☐ Not sexually active ☐ Prefer not to answer

9. Activity, sleep, safety, and daily needs

Exercise (type and days per week) _____ Hours of sleep _____ ☐ Trouble sleeping

Caffeine drinks per day _____ ☐ I wear a seatbelt

Fallen in the past year? ☐ Yes ☐ No

How many falls _____

Feel safe at home? ☐ Yes ☐ No ☐ Talk privately

☐ Food _____

☐ Housing _____

☐ Rides to appointments _____

☐ Utilities _____

☐ None of these

Advance directive? ☐ Yes ☐ No ☐ Unsure

Healthcare power of attorney name _____

10. For children and teens — skip if the patient is an adult

Birth weight ____ Weeks of pregnancy ☐ Full term ☐ Premature ☐ NICU ☐ Vaginal ☐ C-section

☐ Development on track ☐ Early intervention / therapy ☐ IEP / 504 plan ☐ ADHD / learning concern

School / grade _____ Pediatrician or prior doctor _____ ☐ Shots up to date ☐ Unsure

Who else may bring this child to visits, besides the parent or guardian signing today? _____

Name and relationship _____



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11. Women's health — skip if this does not apply

Age at first period _____ First day of last period _____ ☐ Periods regular Menopause — age _____
Pregnancies _____ Births _____ Miscarriages / losses _____ ☐ Currently pregnant ☐ Trying to conceive
☐ Hysterectomy ☐ Not applicable Birth control, if any _____ Last Pap year _____ ☐ Abnormal Pap
Last mammogram year _____

12. Men's health — skip if this does not apply

Last PSA year, if done _____ ☐ Enlarged prostate / BPH ☐ Trouble with urination
☐ Erectile dysfunction

13. Prevention and vaccines

A year is fine. Write "never" or "unsure" if needed.

Last physical _____ Last blood work _____ Last dental exam _____ Last eye exam _____
Colonoscopy year _____ Bone density year _____ Heart screening / stress test year _____
Vaccines (year) Flu _____ COVID _____ Tdap / tetanus _____ Shingles _____ Pneumonia _____
Hepatitis B _____ HPV _____ MMR _____ RSV, if offered _____ ☐ I have shot records with me
☐ Please request shot records

14. Mood over the last 2 weeks

Little interest or pleasure in doing things ☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day
Feeling down, depressed, or hopeless ☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day

15. Review of systems — check anything that is a current or recent problem

General	☐ Fever / chills	☐ Night sweats	☐ Weight change	☐ Fatigue	☐ Poor appetite
Head / ENT	☐ Headaches	☐ Vision change	☐ Hearing change	☐ Ear pain	☐ Congestion
Heart	☐ Chest pain	☐ Palpitations	☐ Leg swelling	☐ SOB with activity	☐ Fainting
Lungs	☐ Cough	☐ Wheeze	☐ SOB at rest	☐ Coughing blood	☐ Snoring
Stomach	☐ Heartburn	☐ Nausea / vomiting	☐ Diarrhea	☐ Constipation	☐ Blood in stool
Urinary	☐ Pain with urination	☐ Frequency / urgency	☐ Up at night	☐ Blood in urine	☐ Leakage
Muscles	☐ Joint pain	☐ Muscle weakness	☐ Joint swelling	☐ Limited motion	☐ Recent injury
Skin	☐ Rash	☐ New or changing mole	☐ Itching	☐ Easy bruising	☐ Non-healing sore
Nerves	☐ Dizziness	☐ Numbness / tingling	☐ One-sided weakness	☐ Memory change	☐ Tremor
Mood	☐ Anxiety	☐ Panic	☐ Low mood	☐ Trouble sleeping	☐ Thoughts of self-harm

If you are having thoughts of harming yourself, tell the front desk now, or call 988 or 911. You do not have to wait for this visit.

Anything else we should know? _____

16. Signature

I have reviewed this form. The information is true and complete to the best of my knowledge. I will tell the office if anything changes.

Patient / parent / guardian signature _____ Print name _____ Date _____

Relationship, if not the patient _____