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NEW PATIENT MEDICAL HISTORY FORM

Date: ____________________

Name: ____

Address: ____

DATE OF BIRTH: _____________ AGE: ______ PRIMARY PHYSICIAN: ___________________________

WHY ARE YOU LEAVING YOUR PHYSICIAN? ____

HOW WERE YOU REFERRED TO OUR OFFICE: ____

INSURANCE: _________________ ID#_________________GROUP#_______EFFECTIVE DATE________

MEDICATION LIST (use separate page if needed)

PLEASE BRING ALL OF YOUR CURRENT MEDICATION BOTTLES WITH YOUR TO YOUR FIRST APPOINTMENT

MEDICATION	DOSE	TIMES PER DAY	MEDICATION	DOSE	TIMES PER DAY

ALLERGIES/SIDE EFFECTS

MEDICATION ALLERGY	REACTION/SIDE EFFECT

PAST MEDICAL HISTORY

MEDICAL CONDITION	DATE OF ONSET	TREATING DOCTOR (if different from Primary Physician)	DETAILS
Aneurysm			
Anxiety			
Arrythmia			
Atrial Fibrillation			
Bleeding Problems			
Blood Clots			
Cancer			
Circulation Problems			
Congenital Heart Disease			
Coronary Heart Disease			
Depression			
Diabetes			
Digestive Problems			
Fainting/Syncope			
Hearing Impaired			Hearing Aid YES or NO Interpreter requested YES or NO
Heart Attack			
Heart Failure			
Heart Murmur			
Heart Valve Problems			
Heartburn			
High Blood Pressure			
High Cholesterol			
Kidney Disease			
Rheumatic Fever			
Seizures			
Sleep Disorders			
Stroke			
Thyroid Problems			
Varicose Veins			
Vision Problems			Glasses/Contacts? YES or NO

OTHER PAST MEDICAL HISTORY: ____
____
____
____

PAST SURGICAL HISTORY

OPERATION	DATE	DETAILS

FAMILY HISTORY

YES or NO	MEDICAL HISTORY	FAMILY MEMBERS	AGES OF ONSET
	Aneurysm		
	Arrythmia		
	Bleeding Problems		
	Blood Clots		
	Circulation Problems		
	Coronary Heart Disease		
	Diabetes		
	Fainting/Syncope		
	Heart Attack		
	Heart Failure		
	Heart Murmur		
	Heart Surgery		
	Heart Valve Problems		
	High Blood Pressure		
	High Cholesterol		
	Kidney Disease		
	Rheumatic Heart Disease		
	Stroke		
	Sudden Death		
	Thyroid Problems		
	Other:		
	Other:		

SOCIAL HISTORY:

Primary Language: ______________________ Translator Needed? YES or NO

Do you have any cultural or religious customs that we should be aware of? YES or NO

If yes, explain ____

TOBACCO	Never	Current	Former	Age of Onset	Packs Per Day	# Years	Year Quit
CIGARETTES							
PIPE							
CIGAR							

ALCOHOL/CONTROLLED SUBSTANCES

TYPE	AMOUNT	FREQUENCY	QUIT

WHAT IS THE NAME ADDRESS AND PHONE NUMBER OF YOUR PHARMACY?______________________
____

WHERE DO YOU GO FOR BLOODWORK? ____Quest ____ Labcorp ____ Hospital _______________
____ Other ____

RECENT HOSPITALIZATION: ____ NO ____YES, Location/Dates: _________________________________
Details: ____

Signature of Patient/Guardian ____

Relationship to Patient ____

Date ___________________________________

PATIENTS UNDER 18

Father/Guardian Name: ____

Mother/Guardian Name: ____

Has patient begun puberty? ____YES ____ NO

If Patient is a girl, has menstruation begun? ____ YES ____ NO

If Patient is a boy, has their voice changed or have facial hair? ____ YES ____ NO