NEW PATIENT MEDICAL HISTORY FORM Today's Date: ____________

Full Name: ____ Birthdate: __________ Age: _____

Reason for visit: ____

ALLERGIES □ No known medication allergies □ No environmental allergies □ No food allergies

Include name of allergy/reaction: ____

____

MEDICATIONS □ None □ Completed attached list to include routine and "as needed" prescriptions, over-the-counter, supplements, inhalers, injections, hormones, etc…

HEALTH MAINTENANCE SCREENING TEST HISTORY □ never had any of the below testing

TEST	APPROX. DATE	PROVIDER/FACILITY	ABNORMAL RESULT?
Colonoscopy			□No Yes:
Cologuard			□No Yes:
Mammogram			□No Yes:
Pap Smear			□No Yes:
Bone Density			□No Yes:
PSA/Rectal			□No Yes:

VACCINATION HISTORY □ never vaccinated □ received typical childhood vaccinations

Last Flu vaccine:	Last tetanus or TDap:
Last Shingles vaccine:	Last Pneumovax:
Other:	Last Prevnar:

WOMEN'S HEALTH HISTORY, if applicable

Date of Last Menstrual Cycle:	Age of Menopause:
Total Number of Pregnancies:	Total Number of Live Births:

OTHER PROVIDERS/SPECIALISTS □ none

SPECIALIST	PROVIDER/OFFICE	SPECIALIST	NAME
Cardiology		Ophthalmology	
Dermatology		Pulmonary	
GI		Other:	
GYN		Other:	

PERSONAL MEDICAL HISTORY □ none

Check if Yes	Disease or Condition (past or current) *write comments as needed next to disease/condition	Check if Yes	Disease or Condition (past or current) * write comments as needed next to disease/condition
	Alcoholism/Substance Abuse		High cholesterol
	Anemia		HIV/AIDS
	Arthritis		Immune system disorders
	Asthma		Kidney diseases
	Bleeding disorder		Liver diseases
	Cancer, type:		Mental health issues
	COPD		Migraines/headaches
	Diabetes		Prostate
	Eye Disorders		Suicide attempt in past
	Gout		Stroke
	Heart Disease		Other:
	Hepatitis		Other:
	High blood pressure (hypertension)		Other:

SURGERIES OR HOSPITALIZATIONS □ none

TYPE	Date	Location/Facility

SOCIAL HISTORY

Any history of tobacco use? □ No Yes: □ cigarettes □ pipe □ cigar □ snuff □ chew □ vape

Current: Packs/day _____ # of years _____ Past: Quit date ___________________ Packs/day_____ # of years_____

Do you drink alcohol? □ No Yes: □ beer □ wine □ liquor # of drinks per week _____

Do you use marijuana or recreational drugs? □No Yes/type: ____

Occupation (or prior occupation): ____

□ retired □ unemployed □ disabled □ prior military Years of Education or highest degree: _________________

Marital status: □ single □ married □ divorced □ widowed □ partner # of children _____

Do you have a living will, advanced directives, healthcare power-of-attorney? □ No □ Yes (please provide copy)

FAMILY HISTORY □ no family history is known □ adopted

RELATION	AGE	STATE OF HEALTH (poor, fair, good, great)	AGE AT DEATH	CAUSE OF DEATH
Father				
Mother				
Brother				
Sister				
Child				

Any history of the following in your **FAMILY**?

Check if Yes	Disease/Condition	Check if Yes	Disease/Condition	Check if Yes	Disease/Condition
	Alcohol/Drug Abuse		Early Death		Thyroid Problems
	Asthma		Heart Disease		Other:
	Cancer		High Cholesterol		Other:
	COPD		Kidney Disease		Other:
	Depression/Anxiety		Migraines		Other:
	Dementia/Alzheimer’s		Stroke		Other:

To the best of my knowledge, the above information is complete and correct.

I understand it is my responsibility to inform my doctor if I, or my minor child, ever has a change in health.

Print name of patient, parent, guardian or representative: ____

Signature of patient, parent, guardian or representative: ____

Relationship to the patient: ______________________________________ **Date:** ______________________

For the office staff, reviewed by: ___________________________________ **Date:** ______________________