



New Patient Medical History

Name: _____ Date of Birth: ___/___/19___ Age: ___ Sex: ___
 How did you hear about our practice?

Past Medical History			
<i>Condition / Disease</i>	<i>Year Began</i>	<i>Condition / Disease</i>	<i>Year Began</i>
<input type="checkbox"/> Hypertension		Other(s):	
<input type="checkbox"/> High Cholesterol			
<input type="checkbox"/> Hypothyroidism (low thyroid)			
<input type="checkbox"/> COPD, Emphysema or Asthma			
<input type="checkbox"/> Diabetes			
<input type="checkbox"/> GERD			
<input type="checkbox"/> Depression or Anxiety			
<input type="checkbox"/> Heart Problems -			

Past Surgical Procedures / Hospitalizations / Serious Injuries or Fractures			
<i>Operation / Hospitalization / Injury</i>	<i>Month / Yr</i>	<i>Operation / Hospitalization / Injury</i>	<i>Month / Yr</i>

Medication or Food Allergies or Intolerances			
<i>List below medications or foods causing an allergic reaction (i.e., rash, swelling) or intolerance (i.e., nausea)</i>			
<i>Medication / Food</i>	<i>Reaction</i>	<i>Medication / Food</i>	<i>Reaction</i>

Medications, Vitamins and Herbal Supplements					
<i>Medication</i>	<i>Strength</i>	<i>Number of pills taken & frequency</i>	<i>Medication</i>	<i>Strength</i>	<i>Number of pills taken & frequency</i>
<i>Example: Tylenol</i>	<i>500 mg</i>	<i>1 - twice daily</i>			

Social, Educational and Work History		
Marital Status:	Age of children, if any:	
Work Status (circle one): Employed Unemployed / Retired / Disabled	Current or Prior Occupation:	Hours worked per week:
Highest Level of Education:	Completed at which institution / school:	
What type of exercises do you perform, duration & frequency?		
In what type of residence do you live (i.e., house, assisted living, nursing home)?		
What are your hobbies?		
Do you drink alcohol?	What type of alcohol?	No. of drinks per week?

Are you a current smoker?	If you smoke, how many packs per day?	
Are you a former smoker?	If so, what year did you quit?	No. of years you smoked?
On average, how much did you smoke per day?		
Are you sexually active: Yes / No	Do you have sex with: Men / Women / Both	How many partners have you had during the past 12 months?
Are you concerned that you may have been exposed to HIV? Yes / No		

Family Health History

Please list below the health history of your blood (genetic) first degree relatives

<i>Relative</i>	<i>Living or Deceased</i>	<i>Current age or age at death</i>	<i>Cause of Death</i>	<i>Health Problems</i>
Father:				
Mother:				
Brother(s):				
Sister(s):				

Review of Systems

Please review the following symptoms and circle those items that are a problem for you

Vision problems	Wheezing	Lumps in breast	Frequent Urination	Excessive hunger
Hearing problems	Asthma / COPD	Breast discharge	Incontinence	Excessive thirst
Sinus trouble	Emphysema	Trouble swallowing	Blood in Urine	Weakness
Hay fever	Bronchitis	Nausea	History of STD's	Fatigue
Nosebleeds	TB exposure	Vomiting	Anemia	Fever / Sweating
Sore throat	Chest pain	Abdominal pain	Easy bruising	Fainting
Hoarseness	Chest discomfort	Hepatitis / Jaundice	Pain in legs	Seizures / Tremor
Lumps in neck	Shortness of breath	Gallstones	Joint pain / stiffness	Headaches
Tooth problems	High blood pressure	Diarrhea	Blood clot	Numbness/tingling
Cough	Diabetes	Constipation	Weight loss / gain	Anxiety/Depression
Coughing blood	High cholesterol	Blood in stool	Heat/cold intolerance	Difficulty sleeping

Place an "X" in the box to the left if you have none of the above.

Disease Prevention and Health Maintenance

Please list below the most recent dates of your vaccines and health screening tests

	<i>Month/Yr</i>		<i>Month/Yr</i>		<i>Month/Yr</i>
Flu Vaccine		Mammogram		Eye Exam	
Pneumonia Vaccine		Pap Smear		Heart Catheterization	
Tetanus Vaccine		Colonoscopy		Endoscopy (EGD)	
Hepatitis B Vaccine		Bone Density		Heart Stress Test	
Shingles Vaccine		EKG		Ab Aneurysm Screen	
Gardasil Vaccine		Chest X-Ray		HIV Test	