NEW PATIENT HISTORY FORM

Name: _____ Sex_____ DOB: _____

PERSONAL HEALTH HISTORY

List any other current problems:

1. _____ 5._____
2. _____ 6._____
3. _____ 7._____
4. _____ 8._____

List any other healthcare providers who have treated you in the past 12 months.

Name:	Condition treated:
1. _____	_____
2. _____	_____
3. _____	_____

Approximate date of last medical exam: _____

Please list any prescription or over the counter medication you are presently taking (include strength and frequency):

1. _____ 5._____
2. _____ 6._____
3. _____ 7._____
4. _____ 8._____

Allergies/Drug sensitivities: _____

Tobacco use: Never _____ Past use:_____ Date quit_____ Currently (amount):_____

Alcohol Use (average/amount): _____

Drug Use: Never _____Past use of _____ Current use of_____

PAST SURGERIES/HOSPITALIZATIONS (please include the dates)

_____

_____

_____

DATE OF LAST:

EKG _____ Blood tests _____ TB test _____ Mammogram _____

Pap _____ Prostate exam _____ Colonoscopy_____Other _____

MEDICAL HISTORY

Please specify if you or any family members have been diagnosed with the following conditions:

Condition	**Self/Date**	**Mother/Date**	**Father/Date**	**Other Family Member/Date**
Hypertension				
High Cholesterol				
Heart Disease				
Stroke				
Diabetes				
Thyroid Problem				
Depression				
Cancer (Specify:)				
Alcoholism				