NEW PATIENT
MEDICAL HISTORY FORM

Full Name: ______________________ Preferred Name : ______________________ Date: ______________________

Birth Date: ______________________ Age: ______________________

Preferred Title please circle one: Ms. Mrs. Miss Mr.

She/her He/Him

ALLERGIES

❑ **NO ALLERGIES**

ALLERGY	ALLERGIC REACTION

MEDICATIONS

MEDICATIONS *(Please list ALL)*	DOSE *(Mg., pill, etc.)*	TIMES PER DAY

If you need more room to list medications, please write them on a blank sheet of paper with the required information

HEALTH MAINTENANCE SCREENING TEST HISTORY

CHOLESTEROL	Date:	Facility/Provider:	Abnormal Result? Y N
COLONOSCOPY/SIGMOID	Date:	Facility/Provider:	Abnormal Result? Y N
MAMMOGRAM	Date:	Facility/Provider:	Abnormal Result? Y N
PAP SMEAR	Date:	Facility/Provider:	Abnormal Result? Y N
BONE DENSITY	Date:	Facility/Provider:	Abnormal Result? Y N

PERSONAL MEDICAL HISTORY

DISEASE/CONDITION	CURRENT	PAST	COMMENTS
Alcoholism/Drug Abuse			
Asthma			
Cancer *(type:_________________________________)*			
Depression/Anxiety/Bipolar/Suicidal			
Diabetes *(type:________________________________)*			
Emphysema *(COPD)*			
Heart Disease			
High Blood Pressure *(hypertension)*			
High Cholesterol			
Hypothyroidism/Thyroid Disease			
Renal *(kidney)* Disease			
Migraine Headaches			
Stroke			
Blood Clotting Disease:			
Other:			

SURGERIES

TYPE *(specify left/right)*	DATE	LOCATION/FACILITY

WOMEN'S HEALTH HISTORY

Date of Last Menstrual Cycle:	Age of First Menstruation: _____ Age of Menopause: _____
Total Number of Pregnancies:	Number of Live Births:
Pregnancy Complications:	History of Sexually Transmitted Infections:

Patient Name: ____ DOB: ______________________

FAMILY MEDICAL HISTORY

❏ **NO SIGNIFICANT FAMILY HISTORY IS KNOWN**

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OTHER HEALTH ISSUES

TOBACCO USE	Smoke Cigarettes? Y N *(If you never smoked, please move to Alcohol /Drug Use)*		
Current: Packs/day _____ # of Years _____	***Past:*** Quit Date: _________________ Packs/day _____ # of Years _____		
Other Tobacco *(check one)*: ❏ Pipe ❏ Cigar ❏ Snuff ❏ Chew			
ALCOHOL/DRUG USE	Do you drink alcohol? Y N	❏ Beer ❏ Wine ❏ Liquor	# of Drinks/week:
Do you use marijuana or recreational drugs? Y N	Have you ever used needles to inject drugs? Y N		
Have you ever taken someone else's drugs? Y N			

Patient Name: ______________________________________ DOB: ____________________

OTHER HEALTH ISSUES continued...

SEXUAL ACTIVITY	Sexually involved currently? Y N *(If no sexual history, please continue to Exercise)*
Sexual partner(s) is/are/have been: ❑ Male ❑ Female	Number of lifetime partners:
Birth control method: ❑ None ❑ Condom ❑ Pill/Ring/Patch/Inj/IUD ❑ Vasectomy	Date of last self breast exam:
EXERCISE	Do you exercise regularly? Y N *(If you answered no, please move to Sleep)*
What kind of exercise?	***Duration:*** How long (min.): _______ How often: ________
SLEEP	How many hours, on average, do you sleep at night *(or during the day, if working night shift)*?
DIET	How would you rate your diet? ❑ Good ❑ Fair ❑ Poor
SAFETY Do you use a bike helmet? Y N	Do you use seat belts consistently? Y N
Working smoke detector in home? Y N	If you have guns at home, are they locked up? Y N
Is violence at home or work a concern for you? Y N	Have you completed an Advance Directive for Health Care (ADHC), Living Will, or Physical Orders for Life Sustaining Therapy (POLST)? Y N

OTHER PROVIDERS/SPECIALISTS

SPECIALIST	NAME	LAST VISIT
Cardiology		
Gastroenterologist (GI)		
OB/GYN		
Neurology		
Pulmonary		
Other:________________________		
Other:________________________		

ADDITIONAL INFORMATION

Have you traveled outside of the country in the last 30 days? Y N	If yes, where?
Have you served in the military? Y N	If yes, how long and what branch?
Were you deployed? Y N	If yes, where?

Patient Name: ____ DOB: ______________________