NEW PATIENT MEDICAL HISTORY FORM (for patients age 21 and older)

Date: _____

Name: _____ Date of birth: _____

Address: _____

Primary Physician: _____How were you referred to our office: _____

Insurance: _____ ID#: _____Group#: _____ Effective: Date_____

What is the name, address, phone number, and fax number of your pharmacy? _____
_____

Where do you go for bloodwork? ☐Quest ☐ Labcorp ☐ Hospital ☐Home Draw ☐Other: _____

Recent hospitalization: ☐ NO ☐YES, Location/Dates: _____
Details: _____

DEMOGRAPHIC AND CULTURAL HISTORY

Primary Language: _____ Translator Services Requested? ☐YES ☐NO

Do you have any cultural or religious customs that we should be aware of? ☐YES ☐NO
If yes, explain _____

RACE: (please circle): White, Black/African American, American Indian/Alaska Native, Asian, Native Hawaiian/Other Pacific Islander, Other_____, Decline/Unknown

PAST MEDICAL HISTORY

Please describe any medical conditions you have related to the following:	**Circle Yes or No**	**Date of onset**	**Treating Doctor** *(if different from Primary Physician)*	**Details**
Eyes, Ears, Nose or Throat	**YES NO**			
Mood, Behavior or Mental Health	**YES NO**			
Heart, Blood Pressure, Circulation or Blood	**YES NO**			
Lungs or Breathing	**YES NO**			
Stomach or Digestion	**YES NO**			
Brain, Spine or Neurological	**YES NO**			

Endocrine: *Examples include Diabetes, Thyroid, & Hormones*	**YES NO**			
Reproduction	**YES NO**			
Bones & Muscles	**YES NO**			
Urinary & Kidneys	**YES NO**			
Skin	**YES NO**			
Sleep	**YES NO**			
Cancer	**YES NO**			

OTHER PAST MEDICAL HISTORY: _____

_____

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

MEDICATION LIST

(use separate page if needed)

Medication *(if different from Primary Physician)*	**Dose**	**Times per day**	**Name of the DR. that orders**	**Refill needed?**
				YES NO
				YES NO
				YES NO
				YES NO
				YES NO
				YES NO
				YES NO

ALLERGIES & SENSITIVITIES

Medication	**Reaction/Side effect**

PAST SURGICAL HISTORY

Operation	**Date**	**Details**

TOBACCO USE

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

FAMILY HISTORY

Medical History	Circle Yes or No	Family Members (circle all that apply)	Age of Onset
Eyes, Ears, Nose or Throat	**YES NO**	**Parent – Grandparent - Sibling - Other**	
Mood, Behavior or Mental Health	**YES NO**	**Parent – Grandparent - Sibling - Other**	
Heart, Blood Pressure, Circulation or Blood	**YES NO**	**Parent – Grandparent - Sibling - Other**	
Lungs or Breathing	**YES NO**	**Parent – Grandparent - Sibling - Other**	
Stomach or Digestion	**YES NO**	**Parent – Grandparent - Sibling - Other**	
Brain, Spine or Neurological	**YES NO**	**Parent – Grandparent - Sibling - Other**	
Endocrine: *Examples include Diabetes, Thyroid, & Hormones*	**YES NO**	**Parent – Grandparent - Sibling - Other**	
Reproduction	**YES NO**	**Parent – Grandparent - Sibling - Other**	
Bones & Muscles	**YES NO**	**Parent – Grandparent - Sibling - Other**	
Urinary & Kidneys	**YES NO**	**Parent – Grandparent - Sibling - Other**	
Skin	**YES NO**	**Parent – Grandparent - Sibling - Other**	
Sleep	**YES NO**	**Parent – Grandparent - Sibling - Other**	
Cancer	**YES NO**	**Parent – Grandparent - Sibling - Other**	
Other:	**YES NO**	**Parent – Grandparent - Sibling - Other**	

Signature of Patient _____ Date: _____