



NEW PATIENT MEDICAL HISTORY FORM

NAME: _____ GENDER: Female / Male DOB: _____ DATE: _____

ALLERGIES: _____

EMERGENCY CONTACT: _____ PHONE NUMBER: _____

List ALL MEDICATIONS you take, including over-the-counter (OTC) medications and vitamins. Include specific doses and when taken. If you don't know, please call your pharmacist to confirm.

Three sets of horizontal lines for listing medications.

PERSONAL MEDICAL HISTORY: (Please circle all that apply)

- ADHD, Crohn's Disease, High Blood Pressure, Parkinson's Disease, Alcoholism, COPD/ Emphysema, High Cholesterol, Peripheral Vascular Disease, Allergies, Seasonal, Dementia / Memory Loss, HIV, Peptic Ulcer, Anemia, Depression, Hepatitis, Psoriasis, Anxiety, Diabetes Type 1 or 2, Irritable Bowel Syndrome, Pulmonary Embolism (PE), Arrhythmia (irregular heart beat), Diverticulitis, Kidney Stones, Rheumatoid Arthritis, Arthritis, DVT (Blood Clot), Kidney Disease, Seizure Disorder, Asthma, GERD (Acid Reflux), Lupus, Sleep Apnea, Bipolar, Glaucoma, Liver Disease, Stroke, Bladder Problems / Incontinence, Heart Disease, Macular Degeneration, Thyroid Disorder, Bleeding Problems, Heart Attack (MI), Migraines, Ulcerative Colitis, Cancer: _____, Hiatal Hernia, Osteopenia/Osteoporosis

Table with 4 columns: Test Name, Date, YES / NO, Normal / Abnormal. Rows include Last Menstrual Period, Colonoscopy, Mammogram, Dexa (Bone Density), Pap, Last Eye Exam, Last Dental Exam, Last Flu Shot.

Other medical problems not listed above:

Two horizontal lines for additional medical problems.

Surgical History: Please list all prior surgeries and approximate dates performed.

Three sets of horizontal lines for listing surgical history.

Flip to other side ->

SOCIAL / CULTURAL HISTORY:

Education Level: Elementary High School Vocational College Graduate / Professional

Are there any vision problems that affect your communication? Yes No

Are there any hearing problems that affect your communication? Yes No

Are there any limitations to understanding or following instructions (either written or verbal)? Yes No

Current Living Situation (Check all that apply):

Single Family Household Multi-generational Household Homeless Shelter Skilled Nursing Facility

Other: _____

Smoking/ Tobacco Use: Current Past Never Type: _____ Amount/day: _____ Number of Years: _____

Alcohol: Current Past Never Drinks/week: _____

Recreational Drug Use: Current Past Never Type: _____

Are you sexually active? Yes No

Are there any personal problems or concerns at home, work, or school you would like to discuss? Yes No

Are there any cultural or religious concerns you have related to our delivery of care? Yes No

Are there any financial issues that directly impact your ability to manage your health? Yes No

How often do you get the social and emotional support you need? Always Usually Sometimes Rarely Never Comments

(Please feel free to comment on any answers marked "yes" above):

FAMILY HISTORY:

FATHER: Living: Age _____ Deceased: Age _____

Alcoholism	Cancer: _____	DVT (Blood Clot)	Migraines
Anemia	COPD/Emphysema	Heart Disease	Osteoporosis
Asthma	Dementia	High Cholesterol	Stroke
Arthritis	Depression	High Blood Pressure	Thyroid Disorder
Bipolar Disorder	Diabetes 1 or 2	Kidney Disease	

Other: _____

MOTHER: Living: Age _____ Deceased: Age _____

Alcoholism	Cancer: _____	DVT (Blood Clot)	Migraines
Anemia	COPD/Emphysema	Heart Disease	Osteoporosis
Asthma	Dementia	High Cholesterol	Stroke
Arthritis	Depression	High Blood Pressure	Thyroid Disorder
Bipolar Disorder	Diabetes 1 or 2	Kidney Disease	

Other: _____

SIBLINGS: _____

List other medical providers you see on a regular basis (i.e. Cardiologist, Mental Health Provider, Kidney Doctor, Dentist, etc.)

Patient Signature: _____ Date: _____