New Patient
Medical History Form

Full Name: ______________________________________ Date:_________________________________
Birth Date: ______________________________________ Age:_________________________________
Email: ____ Gender: _____________________________
Preferred Phone: _______________________________ Need Interpreter: Y / N
PCP: ____
Other Providers (this condition):____

Allergies

□ **NO Allergies**

Allergy	Allergic Reaction

Medications

Medications	Dose	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

Colonoscopy / Sigmoid	Date:	Facility/Provider	Abnormal Result? Y / N
Mammogram	Date:	Facility/Provider	Abnormal Result? Y/ N

Personal Medical History

Disease / Condition	Current	Past	Comments
Alcoholism/Drug Use			
Asthma			
Autoimmune Disease			
Bleeding Disorder			
Blood Clotting Disorder			
Cancer (type: ______________________)			
Depression/Anxiety/Bipolar/Suicidal			
Diabetes (type: ____________________)			
Emphysema (COPD)			
Heart Disease			
High Blood Pressure (hypertension)			
High Cholesterol			
Parathyroid/Thyroid Disease			
Renal (kidney) Disease			
Stroke			
Other			

Surgeries

Type (specify left/right)	**Date**	**Location/Facility**

Patient Name: ____ DOB:________________________

Social History

Occupation (or prior Occupation):	□ Retired □ Unemployed □ LOA □ Disabled
Employer:	Years of Education or Highest Degree:
Marital Status: □ Single □ Partner □ Married □ Divorced □ Widowed	Do you have children? Y / N
History of Physical or Emotional Abuse: Y / N	

Other Health Issues

Tobacco Use: Cigarettes Y / N	Current: Packs/day __________ # of Years ___________
Other Tobacco: □Vape □Pipe □Cigar □Snuff □Chew	Past: Quit Date: ___________ # of Years ___________
Marijuana Use: Y / N	If yes type: □CBD □THC
Recreational Drug Use: Y / N	
Alcohol Use: Y / N	Type: □Beer □Wine □Liquor # of Drinks/week: ______

Family Medical History

□ No Significant Family History/Family History Unknown

	Condition / Type if Known
Mother	
Father	
Brother	
Sister	
Child	
Maternal Grandmother	
Maternal Grandfather	
Paternal Grandmother	
Paternal Grandfather	

Patient Name: ____ DOB: ________________