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New Patient Medical History

Patient Information

Name _____ _____ Birthdate _____ Sex __ Primary Phone _____
LAST *FIRST* *MIDDLE INITIAL* *MM/DD/YYYY* ❑ Home / ❑ Work / ❑ Cell

Email _____ Marital Status __ Occupation _____ Secondary Phone _____
❑ Home / ❑ Work / ❑ Cell

Doctor / Emergency Contact

Referring Doctor _____ Phone Number _____

Primary Care Doctor *(if different)* _____ Phone Number _____

Emergency Contact _____ Relationship: _____ Cell Phone _____
LAST *FIRST*

Medical History

Have you ever experienced or been diagnosed with any of the following conditions?

❑ High blood pressure	❑ Stroke	❑ Diabetes	❑ Kidney disease
❑ Heart murmur	❑ High cholesterol	❑ Sleep apnea	❑ Liver disease
❑ Angina	❑ Fainting/Dizziness	❑ Autoimmune disease	❑ Thyroid disease
❑ Heart attack	❑ Vascular disease	❑ Lung disease	❑ Cancer Type:
❑ Irregular heart rhythm	❑ Aortic aneurysm	❑ Stomach/intestinal problems	❑ Other _____

Details on conditions selected above, if needed _____

_____

Surgical History: please list the name and date of any surgeries you have had _____

_____

_____

Hospitalizations: please list the date, location, and reason for any prior hospitalizations _____

_____

_____

Check any vaccinations you have received, including dates if known.

❑Influenza _____ ❑ Shingles _____ ❑ Pneumonia _____ ❑ Hepatitis A _____ ❑ Gardasil _____

❑COVID-19 _____ ❑ RSV _____ ❑ TDAP *(tetanus)* _____ ❑ Hepatitis B _____ ❑ Other __ _____

Do you have known allergies (e.g. medications, foods, latex…)? ***Yes No (circle)*** If yes, list the allergies and what reaction you have had to each. _____

_____

Do you take any over the counter vitamins or supplements? ***Yes No (circle)*** If yes, write them below.

_____

List all medications you are currently taking.

Medication	Dose	# times/day	Medication	Dose	# times/day

Check Have you had any of the following screening exams?

	Date	Doctor/Location
❑ Colonoscopy		
❑ Skin exam		
❑ Eye exam		

WOMEN ONLY	Date	Doctor/Location
❑ GYN exam		
❑ Mammogram		
❑ Bone density scan		

Personal History

Yes No Do you currently smoke? ❑Cigarettes ❑Pipe ❑Cigars ❑Vaping #daily___ #years___

Yes No Have you ever smoked? ❑Cigarettes ❑Pipe ❑Cigars ❑Vaping #daily___ #years___ Date stopped ____

Yes No Do you drink alcohol? If yes, # days per week __, # glasses/week of wine __/beer__/liquor __

Yes No Do you use any recreational drugs or substances? If yes, please specify: _____

Yes No Do you drink coffee? # cups daily _____

Yes No Do you follow a specific diet? Please specify _____

Yes No Do you exercise regularly? Type and frequency _____

_____

How would you rate your overall level of physical activity? ❑Low ❑Moderate ❑High

How would you rate your overall level of stress? ❑Low ❑Moderate ❑High

How many hours of sleep do you get per night on average? _____

WOMEN ONLY

#pregnancies ____ #children ____

Were you diagnosed with any of these conditions during any of your pregnancies?

❑ Gestational hypertension
❑ Pre-eclampsia/eclampsia
❑ Gestational diabetes
❑ Preterm labor

Any other complications of pregnancy?

_____
_____
_____

Family History

Provide information for biological relatives only. If deceased, please list their cause of death, if known.

Father: ☐ Alive, age ____ ☐ Deceased, age ____ Medical Problems: _____

Mother: ☐ Alive, age ____ ☐ Deceased, age ____ Medical Problems: _____

Siblings: *(please circle to indicate brother or sister)*

Brother/Sister: ☐ Alive, age ____ ☐ Deceased, age ____ Medical Problems: _____

Brother/Sister: ☐ Alive, age ____ ☐ Deceased, age ____ Medical Problems: _____

Brother/Sister: ☐ Alive, age ____ ☐ Deceased, age ____ Medical Problems: _____

Brother/Sister: ☐ Alive. age ____ ☐ Deceased, age ____ Medical Problems: _____

Do you have any children? ☐ No ☐ Yes, # sons ___ # daughters ___

Chief Complaint

What symptoms or concerns bring you to the doctor today? Please describe briefly_____

_____

_____

_____

_____

_____