



New Patient History

Please fill out this health information form as completely as possible.

Name: _____ Date of Birth: _____

Referring Physician: _____

Preventative Health

Mammogram (Date): _____ Colonoscopy (Date): _____

Past Medical History

- | | | |
|---|--|---|
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Gout | <input type="checkbox"/> Nicotine use |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Phlebitis |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Renal failure |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart Trouble | <input type="checkbox"/> Reflux |
| <input type="checkbox"/> Atrial fibrillation | <input type="checkbox"/> Kidney stones | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Bleeding disorders in yourself or family members | <input type="checkbox"/> Kidney Troubles (Other) | <input type="checkbox"/> Serious injuries |
| <input type="checkbox"/> Blood clots | <input type="checkbox"/> Liver trouble | <input type="checkbox"/> Sleep Apnea |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Lung disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Depression/ Anxiety | <input type="checkbox"/> Mental illness | <input type="checkbox"/> Thyroid trouble |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> MRSA infection | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> None | <input type="checkbox"/> Multiple miscarriages | <input type="checkbox"/> Ulcer |
| | <input type="checkbox"/> Other (Specify): _____ | |

Past Surgical History

Mark each surgery with the approximate date it was done:

- | | |
|--|---|
| <input type="checkbox"/> Back surgery _____ | <input type="checkbox"/> Pacemaker _____ |
| <input type="checkbox"/> Bowel surgery _____ | <input type="checkbox"/> Plastic surgery (type) _____ |
| <input type="checkbox"/> C-section _____ | <input type="checkbox"/> Removal of appendix _____ |
| <input type="checkbox"/> Gastric surgery _____ | <input type="checkbox"/> Removal of gallbladder _____ |
| <input type="checkbox"/> Heart stents _____ | <input type="checkbox"/> Removal of kidney _____ |
| <input type="checkbox"/> Hernia repair (type) _____ | <input type="checkbox"/> Shoulder surgery _____ |
| <input type="checkbox"/> Hip surgery _____ | <input type="checkbox"/> Thyroid/Parathyroid _____ |
| <input type="checkbox"/> Hysterectomy w/w/o removal of ovaries _____ | <input type="checkbox"/> Tonsillectomy _____ |
| <input type="checkbox"/> Knee surgery _____ | <input type="checkbox"/> Weight loss surgery _____ |
| <input type="checkbox"/> Open heart surgery _____ | <input type="checkbox"/> Other _____ |
| | <input type="checkbox"/> None |

Medications

List all prescription and non-prescription medications (including vitamins, supplements, over-the-counter, etc.):

Blood Thinners (e.g. Aspirin, Plavix, Warfarin): _____

Medications	Dosage
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Preferred Pharmacy: _____



New Patient History Continued

Allergies

- Penicillin Sulfa Sutures Latex Tape Skin glue Contrast dye
 None Other: _____

Family Medical History

Place a check mark in the appropriate boxes to identify all illnesses/conditions which you know have occurred in your blood relatives. Do NOT include yourself.

Illness/Condition	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	Father	Mother	Brother	Sister
<input type="checkbox"/> Adopted/ Do not know family history								
Cancer-List type:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kidney trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stroke/TIA	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mental Illness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anesthesia Complications	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
DVT/ Pulmonary embolism	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Social History

Marital Status: Single Married Divorced Widowed

Occupation: _____ Full-time Part-time Retired

Are you involved with any of the following:

- Disability claim Worker's compensation Lawsuit

Number of pregnancies: _____ Number of living children: _____

Presently living alone? Yes No

Do you use tobacco? Yes No e-cigarettes? Yes No If yes, how much?

Former smoker? Yes No

Do you drink alcohol? Yes No If yes, how much?

Do you use illicit drugs? Yes No If yes, how much?