New Patient Health History

Name:_____ DOB:_____ Sex:_____

Any current health issues to discuss at initial visit

Drug Allergies/ Intolerance	Reaction	Food Allergies	Reaction

Medication/Supplements, Strength, How Many and Frequency

Speciality Providers

Past Medical History	Year Began	Past Medical History	Year Began
___Hypertension		___Heart Issues	
___High Cholesterol		___Other	
___Asthma/COPD			
___Thyroid Disease			
___Diabetes			
___GERD			
___Anxiety/Depression			

Prior Surgery/Hospitalizations/Serious Injuries	Year

Relative	Living or Deceased	Health Issues
Mother		
Father		
Brother(s)		
Sister(s)		
Grandparents Paternal		
Grandparents Maternal		

Health Maintenance	Year	Health Maintenance	Year
Tdap		Mammogram	
Flu		Pap	
Pneumonia		DEXA	
Shingles		Colonoscopy	
Dental Exam		Eye Exam	

Social, Education and Work History
Married___ Single___ Children____
Work Status: (circle one) Employed / Unemployed / Retired / Disabled
Occupation:
Education Level:
Exercise: What/How often per week
What are your hobbies?
Do you drink alcohol? ___ What type of alcohol do you drink No. drinks per week?____
Do you smoke? ____ How much per day? ____ No. of years smoking?____
Are you a former smoker?___ When did you quit? ____ No. of years smoked?____
Have you ever served in the military? ____ If yes, what branch?