New Patient Health History Form

Name: _____ Date: _____

Past Medical History

Do you have or have you ever had any of the following conditions?

	Y/N		Y/N		Y/N		Y/N
High Blood Pressure	☐ ☐	Anemia	☐ ☐	Irregular Heart Beat	☐ ☐	Depression	☐ ☐
Low Blood Pressure	☐ ☐	Blood Disorder	☐ ☐	Asthma	☐ ☐	Anxiety	☐ ☐
High Cholesterol	☐ ☐	Heart Murmur	☐ ☐	Chronic Cough	☐ ☐	Ulcer(s)	☐ ☐
Diabetes	☐ ☐	Chest Pain/Angina	☐ ☐	COPD	☐ ☐	Hepatitis	☐ ☐
Thyroid Disease	☐ ☐	Heart Attack(s)	☐ ☐	Sleep Apnea	☐ ☐	Heartburn	☐ ☐
Cancer	☐ ☐	Fatty Liver	☐ ☐	Breathing Problems	☐ ☐	Reflux	☐ ☐

Type_____

Please list all other conditions: _____

Family Medical History

Have any of your blood relatives ever been diagnosed with the following conditions? (Parents, Grandparents, Brothers, Sisters)

	Y/N	If yes, relationship to you:		Y/N	
High Blood Pressure	☐ ☐	_____	Arthritis	☐ ☐	_____
High Cholesterol	☐ ☐	_____	Kidney Disease	☐ ☐	_____
Diabetes	☐ ☐	_____	Asthma	☐ ☐	_____
Heart Disease	☐ ☐	_____	Cancer	☐ ☐	_____
Stroke	☐ ☐	_____	Type		_____
Thyroid Disease	☐ ☐	_____			

Other (please describe): _____

Social History

Do you now, or have you ever, used any of the following:

	Y/N	If yes, what type, how much and how often?
Tobacco/Nicotine/E-cig/Vape:	☐ ☐	_____
Alcohol:	☐ ☐	_____
Caffeine:	☐ ☐	_____
Recreational Drugs	☐ ☐	_____

Medications

Medication	Dose	Frequency	Medication	Dose	Frequency

Allergies (include reaction): _____

Preferred Pharmacy #1: _____ Location: _____ Phone: _____

Preferred Pharmacy #2: _____ Location: _____ Phone: _____

Do you have a living will or advanced directive? (Circle One) Yes No

Emergency: Contact:

Name: _____ Relationship: _____

Phone Number 1: _____ Phone #2 (if applicable): _____