



## New Patient Form

First Name:

Last Name:

Date of Birth:

Mailing Address:

Email Address:

Preferred Language:

Social Security Number:

Preferred Communication:    phone    email    mail

Primary phone number:

Home Phone:

Cell Phone:

Work Phone:

Is it ok to leave messages on the above phone number regarding specific information to your health:    YES    NO

Allergies to Medications:

Multiple Birth? YES NO

Mother's Maiden Name:

How did you hear about IHC:

Primary Care Provider's:

Name:

Number:

Address

If under 18 years of age: Primary Care Giver:

Name:

Number:

Relationship:

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**Food Allergies:**

Food	Reaction	Severity
_____	_____	_____
_____	_____	_____
_____	_____	_____

**Food Intolerances:**

Food	Reaction	Severity
_____	_____	_____
_____	_____	_____
_____	_____	_____

**Drug Allergies:**

Drug	Reaction	Severity
_____	_____	_____
_____	_____	_____
_____	_____	_____

**Drug Intolerances:**

Drug	Reaction	Severity
_____	_____	_____
_____	_____	_____
_____	_____	_____

**Environmental Allergies:**

Allergen	Reaction	Severity
_____	_____	_____
_____	_____	_____
_____	_____	_____

**Diagnosis:**

Diagnosis	Doctor Name & Specialty	Date
_____	_____	_____
_____	_____	_____
_____	_____	_____

**List of your current medical providers & specialty:**

Provider & Specialty	Address	Phone
_____	_____	_____
_____	_____	_____
_____	_____	_____

**List of your current medications:**

Drug	Dose	Start Date
_____	_____	_____
_____	_____	_____
_____	_____	_____

**List of your current supplements:**

Drug	Dose	Start Date
_____	_____	_____
_____	_____	_____
_____	_____	_____

Are you up-to-date on vaccinations?   YES   NO

**List any Hospitalizations/Surgeries (place, reasons & dates)**

Name and Location	Reason	Date
_____	_____	_____
_____	_____	_____
_____	_____	_____

**Patient's Brothers/Sisters and their Children**

List your brothers/sisters.

Please include stillbirths(sb), miscarriages(m) and those deceased(d).

Name of Sibling	Date of Birth	Sex	Present Health	Sibling's Children
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Are any of the above half-brothers/sisters and/or step-brothers/sisters? \_\_\_\_\_  
\_\_\_\_\_

Are any of the above adopted or foster children? \_\_\_\_\_  
\_\_\_\_\_

**Biological Mother**

Date and place of birth \_\_\_\_\_

Ethnic origin \_\_\_\_\_  
Present Health \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Maternal Grandfather**

Ethnic origin \_\_\_\_\_  
Date & Place of Birth \_\_\_\_\_  
How many brothers? \_\_\_\_\_  
How many sisters? \_\_\_\_\_  
Present Health (if deceased, date and cause of death) \_\_\_\_\_  
\_\_\_\_\_

**Maternal Grandmother**

Ethnic origin \_\_\_\_\_  
Date & Place of Birth \_\_\_\_\_  
How many brothers? \_\_\_\_\_  
How many sisters? \_\_\_\_\_  
Present Health (if deceased, date and cause of death) \_\_\_\_\_  
\_\_\_\_\_

Is there anyone else on the maternal side of the family that has any birth defects, mental retardation, or any other health concerns not yet mentioned? List each person affected and identify the problems.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Biological

**Biological Father**

Date and place of birth \_\_\_\_\_  
Ethnic origin \_\_\_\_\_  
Present Health \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Paternal Grandfather**

Ethnic origin \_\_\_\_\_  
Date & Place of Birth \_\_\_\_\_

How many brothers? \_\_\_\_\_

How many sisters? \_\_\_\_\_

Present Health (if deceased, date and cause of death) \_\_\_\_\_  
\_\_\_\_\_

**Paternal Grandmother**

Ethnic origin \_\_\_\_\_

Date & Place of Birth \_\_\_\_\_

How many brothers? \_\_\_\_\_

How many sisters? \_\_\_\_\_

Present Health (if deceased, date and cause of death) \_\_\_\_\_  
\_\_\_\_\_

Is there anyone else on the paternal side of the family that has any birth defects, mental retardation, or any other health concerns not yet mentioned? List each person affected and identify the problems.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Patient's Children**

List your children

Please include stillbirths(sb), miscarriages(m) and those deceased(d).

Name of Child	Date of Birth	Sex	Present Health	Grand Children
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

**Dental Health**

Do you visit the dentist every 6 months? YES NO

When was the last time you went to the dentist?

Do you have any cavities? YES NO

If yes, how many?

What color are the fillings?

When did you get the fillings (year and age):

Have you ever had any fillings removed?

Have you ever had a root canal?

If yes, how many? (Year, Age):

### **Travel**

Have you lived or traveled outside the USA? YES NO

Where and when?

Did you fall ill during or after a trip?

Have you ever traveled or lived on the East Coast?

Minnesota?

Wisconsin?

Have you ever been bit by a tick?

Have you ever had a bullseye rash?

Have you ever lived or worked in a building with a known mold problem?

### **Environmental Exposure**

Have you ever been exposed to known heavy metals at work or home?

Have you ever lived in a home with well water?

Have you been exposed to broken florescent light bulbs?

Have you been exposed to broken mercury thermometers?

Have you been exposed to a dental office besides normal checkups?

**List all your past and present occupations**

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**Other Exposures**

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