Buffalo Trace Medical Arts
A Division of Comprehend, Inc.

New Patient Health Form

Name: _____ Age: _____

Sex: _____ Marital Status: _____

Date of Birth: _____

Occupation: _____ Check if Retired: __

Last Grade Finished: _____

Hobbies/Interests: _____

Date of Visit: _____ Reason for Visit: _____

_____

_____

FAMILY HEALTH

	Good	Poor	Died	Age & Cause of Death
Grandfathers (natural)	☐	☐	☐	_____
Grandfathers (natural)	☐	☐	☐	_____
Grandmothers (natural)	☐	☐	☐	_____
Father (natural)	☐	☐	☐	_____
Mother (natural)	☐	☐	☐	_____
Brothers/Sisters (natural)	☐	☐	☐	_____
_____	☐	☐	☐	_____
_____	☐	☐	☐	_____
_____	☐	☐	☐	_____
Children (natural)	☐	☐	☐	_____
_____	☐	☐	☐	_____
_____	☐	☐	☐	_____
_____	☐	☐	☐	_____

IMMUNIZATIONS/VACCINES Note year last received.

☐ Pneumonia _____ ☐ Measles _____ ☐ Mumps _____

☐ Influenza _____ ☐ Tetanus _____ ☐ Rubella _____

☐ Polio _____ ☐ Hepatitis B _____ ☐ Hepatitis A _____

WOMEN'S GYNECOLOGIC HISTORY

Age when menses first began: _____

Date of last menstrual period: _____

Number of pregnancies: _____

Number of live births: _____

MEDICATION/FOOD/PRODUCT ALLERGIES
List and explain nature of reaction.

_____

_____

_____

_____

ILLNESSES Check the **S** box if **you've** ever had any of the following. Check the **BR** box if a close **blood relative** has ever had any of these.

S	BR		S	BR	
☐	☐	Alcoholism	☐	☐	Suicide Attempt
☐	☐	Anemia	☐	☐	Eye Problems
☐	☐	Arthritis	☐	☐	Blood Clot
☐	☐	Bleeding Easily	☐	☐	Thyroid Disease
☐	☐	Blood Transfusion	☐	☐	Venereal Disease
☐	☐	Diabetes	☐	☐	Cancer
☐	☐	Drug Abuse	☐	☐	High Blood Pressure
☐	☐	Depression	☐	☐	Stomach Ulcer
☐	☐	Skin Problems	☐	☐	Stroke
☐	☐	Liver Disease	☐	☐	Kidney Disease
☐	☐	Lung Disease	☐	☐	Measles, mumps
☐	☐	Seizures/epilepsy	☐	☐	Rubella
☐	☐	Heart Disease	☐	☐	Chicken Pox
☐	☐	Rheumatic Fever	☐	☐	Osteoporosis
☐	☐	EnvironmentalAllergies	☐	☐	HIV/AIDS
☐	☐	Other _____	☐	☐	Mental Illness
		_____	☐	☐	Other _____
☐	☐	Other: _____			_____
		_____			_____

HOSPITALIZATIONS/SURGERIES
List illnesses and operations with year.

_____

_____

_____

_____

_____

_____

MEDICATIONS/SUPPELMENTS YOU ARE USING List those by prescription and those over-the-counter, dose, and how used.

_____

_____

_____

_____

_____

Patient Signature: _____ Date: _____