

New Patient Medical History - Please complete this two-sided form

Name: _____ Date of Birth: ___/___/____ Age: ____ Sex: ____
 How did you hear about our practice?

◆ Please briefly state in the box below the reason for your visit ◆

◆ Past Medical History ◆

<i>Condition / Disease</i>	<i>Year Began</i>	<i>Condition / Disease</i>	<i>Year Began</i>
<input type="checkbox"/> Hypertension		GERD	
<input type="checkbox"/> High Cholesterol		Depression or Anxiety	
<input type="checkbox"/> Thyroid Problems		Heart Problems -	
<input type="checkbox"/> COPD, Emphysema or Asthma		Other(s):	
<input type="checkbox"/> Diabetes			
<input type="checkbox"/>			

◆ Past Surgical Procedures / Hospitalizations / Serious Injuries or Fractures ◆

<i>Operation / Hospitalization / Injury</i>	<i>Month / Yr</i>	<i>Operation / Hospitalization / Injury</i>	<i>Month / Yr</i>

◆ Other Physicians and Specialists ◆

List below your other physicians (i.e., Gyn, Dermatology, GI, Orthopedics, Urology, Psychiatry, etc)

◆ Medication or Food Allergies or Intolerances ◆

List below medications or foods causing an allergic reaction (i.e., rash, swelling) or intolerance (i.e., nausea)

<i>Medication / Food</i>	<i>Reaction</i>	<i>Medication / Food</i>	<i>Reaction</i>

◆ Family Health History ◆

Please list below the health history of your blood (genetic) first degree relatives

<i>Relative</i>	<i>Living or Deceased</i>	<i>Current age or age at death</i>	<i>Cause of Death</i>	<i>Health Problems</i>
Father:				
Mother:				
Brother(s):				
Sister(s):				

◆ Disease Prevention and Health Maintenance ◆

Please list below the most recent dates of your vaccines and health screening tests

	<i>Month/Yr</i>		<i>Month/Yr</i>		<i>Month/Yr</i>
Flu Vaccine		Mammogram		Eye Exam	
Pneumonia Vaccine		Pap Smear		Heart Catheterization	
Tetanus Vaccine		Colonoscopy		Endoscopy (EGD)	
Hepatitis B Vaccine		Bone Density		Heart Stress Test	
Shingles Vaccine		EKG		Ab Aneurysm Screen	
COVID Vaccine		Other:			

