NEW PATIENT-Medical History Form Today's Date_____

Name: _____DOB: _____

Current or Previous Occupation: _____

Reason For Today's Visit: _____

Current Local Pharmacy: _____

Mail Order Pharmacy: _____

Allergies: please include medications, food, topical agents, or IV dyes or circle **NO KNOWN ALLERGIES**

NAME OF ALLERGEN	WHAT TYPE OF REACTION	APPROX DATE

Current Medications: Please include prescription, OTC and herbal supplements and who prescribes them. If given to you by a specialist—attach extra sheets if needed.

Medication	Dose	How Often Taken	Why do you take this	Who Prescibes

SURGERIES: Please include all surgeries in your lifetime—attach extra sheets if needed.

Type of Surgery	Approximate Date	Hospital or City	

OTHER HOSPITAL STAYS OR SEVERE ILLNESS: please attach extra sheets if needed.

Reason for Hospital Stay	**Approximate Date**	**Hospital or City**

OB-GYN HISTORY: # of pregnancies_____ # of deliveries_____

Last Menstrual Cycle (1st day of cycle)

TOBACCO HISTORY:

Do you (or did you ever) smoke cigarettes, cigars, pipe or vape? **YES** or **NO**

Any other tobacco products (dip/snuff/etc) **YES** or **NO**

If so, how old were you when you started? _____ When did you Quit? _____

ALCOHOL AND DRUG HISTORY:

Do you currently drink alcohol regularly? **YES** or **NO**

If so, how often: (circle one) **DAILY** **WEEKLY** **LESS OFTEN THAN WEEKLY**

On average, how many drinks per week, 1 drink is defined as 12oz beer, 5oz wine, or 1 ounce of liquor

Have you ever been diagnosed with alcoholism? **YES** or **NO**

Have you ever used IV drugs? **YES** or **NO** Have you ever been in rehab for any substance **YES** or **NO**

FAMILY HISTORY:

FAMILY MEMBER	**CURRENT AGE**	**MAJOR HEALTH ISSUES**	**CAUSE OF DEATH**
Mother			
Father			
MGM			
MGF			
PGM			
PGF			
Siblings			

Any Cancer? **YES** or **NO** Any heart Disease or Stroke? **YES** or **NO** Diabetes? **YES** or NO

PREVENTATIVE HEALTH:

SERVICE	RECENT DATE	SERVICE	RECENT DATE	
Flu Vaccine		Colonoscopy		
Prevnar-13		Mammogram		
Pneumovax-23		Pap Smear		
Tdap		Bone Density		
Shingles (2 doses)		Eye Exam		
Hepatitis B		PSA (Prostate)		
Hepatitis A		EKG		