Date ____/____/____

NEW PATIENT HEALTH HISTORY

Name: ____ M / F Date of Birth: ___________________

Tobacco Use: NOW PAST Type: _____________ How Much?: ______________________________

Alcohol Use NOW PAST Type: _____________ How Much?: ______________________________

Non-Prescription Drug Use: NOW PAST Type: _____________ How Much?: __________________

Previous Surgeries ____

Medical Problems ____

____

Allergic to Medications? Y N Which Meds? ____

Current Medications ____________________ ______________________ _____________________

Supplements ____________________ ______________________ _____________________

Primary Care MD ______________________ Last Exam ____/____/____ Last Tetanus ___/____/____

OB/GYN ____________________________ Last Exam ____/____/____

Family History: (List relationship) Diabetes Y N _____________ Heart Disease Y N _____________

Cancer Y N Type: ____________ Rel. _____________ Other ___________________________________

Married / Single / Divorced # of Children _______ Ages _________________________________

Other Social History: ____

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