NEW PATIENT HEALTH HISTORY FORM

Patient Name: _____Birthdate: _____ Date: _____

Referring Physician: _____ Address: _____
Pharmacy Name: _____Phone number: (____)_____

Reason for today's visit: _____
Please describe this problem: _____
_____

PRIOR SURGERIES	CURRENT/PRIOR ILLNESSES/INJURIES

Please list all medications (prescriptions and non-prescription) that you take.
(Include herbal remedies, vitamins, over-the-counter, street drugs, prescriptions, etc.)

MEDICATION	DOSAGE	MEDICATION	DOSAGE

Do you take any blood thinning products such as **Vitamin E, Plavix, Coumadin, Aspirin**? ☐No ☐Yes

Do you have any food, environmental, or drug allergies? ☐No ☐ Yes (please explain below)

ALLERGY	TYPE	REACTION

Do you smoke? ☐No, and never have ☐ Yes (please explain below)

TYPE OF SMOKING(cigarette, pipe, marijuana, chew, etc)	HOW MUCH	HOW LONG

Do you drink alcohol? ☐ No, and never have ☐ Socially only ☐ Daily ☐ Beer/Wine ☐ Hard Liquor
Occupation: _____ Hand Dominance: RIGHT LEFT

Please describe any family health issues below.

FAMILY HISTORY	Good/None	Unknown	Illnesses/Reason for Death
Mother			
Father			
Sibling(s)			
Other hereditary illness			

Patient Signature: _____ Date: _____

Physician Signature: _____ Date reviewed: _____

(Continue on back)

HEALTH HISTORY FORM PAGE 2

Do you have or have you ever had any of the following:

Symptom/Illness	No	Yes, explain	Symptom/Illness	No	Yes, explain
Constitutional			**Skin**		
Fever or Chills			Breast Abnormalities		
Weight Loss			Nipple Discharge		
Hematologic			Last Mammogram		Date: ____/____/_____
Heaptitis			Changes in moles		
HIV/Other Blood Diseases			Lesions		
Bleeding Disorders			Rashes		
Endocrine			History of Keloids		
Thyroid Problems			**Neurological**		
Diabetes			Neurological Problems		
Musculoskeletal			Headaches		
Arthritis			**Genitourinary**		
Mobility/Join Problems			Genital or Oral Herpes		
Gastrointestinal			Sexually Transmitted Disease		
Constipation			Blood in Urine		
Diarrhea			Urinary Tract Infection		
Blood in Stool			Problems Urinating		
Nausea/Vomiting			Prostate Problems		
Liver Problems			Kidney Problems		
Cardiovascular			**Eyes**		
Heart Problems			Vision Problems		
Deep Vein Thrombosis/DVT			**ENT**		
Blood Clots in Lungs/Legs			Hearing Problems		
High Blood Pressure			Sinus Problems		
Respiratory			**Psychiatric**		
Asthma			Mood Swings		
Sleep Apnea			Anxiety/Depression		

Please list any other conditions/illnesses not indicated above: _____

_____

To the best of my knowledge, this information is complete and correct. I understand that it is my responsibility to inform my doctor if there are any changes in my health.

Patient Signature: _____ Date: _____

Physician Signature: _____Review Date: _____