New Patient History

Please fill out this health information form as completely as possible.

Name: _____ Date of Birth: _____

Referring Physician: _____

Preventative Health

Mammogram (Date): _____ Colonoscopy (Date): _____

Past Medical History

- ☐ Alcoholism
- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Atnal fibrillation
- ☐ Bleeding disorders in yourself or family members
- ☐ Blood clots
- ☐ Cancer
- ☐ Depression/ Anxiety
- ☐ Diabetes
- ☐ None
- ☐ Gout
- ☐ Hepatitis
- ☐ High blood pressure
- ☐ Heart Trouble
- ☐ Kidney stones
- ☐ Kidney Troubles (Other)
- ☐ Liver trouble
- ☐ Lung disease
- ☐ Mental illness
- ☐ MRSA infection
- ☐ Multiple miscarriages
- ☐ Other (Specify): _____
- ☐ Nicotine use
- ☐ Phlebitis
- ☐ Renal failure
- ☐ Reflux
- ☐ Seizures
- ☐ Serious injuries
- ☐ Sleep Apnea
- ☐ Stroke
- ☐ Thyroid trouble
- ☐ Tuberculosis
- ☐ Ulcer

Past Surgical History

Mark each surgery with the approximate date it was done:

- ☐ Back surgery _____
- ☐ Bowel surgery _____
- ☐ C-section _____
- ☐ Gastric surgery _____
- ☐ Heart stents _____
- ☐ Hernia repair (type) _____
- ☐ Hip surgery _____
- ☐ Hysterectomy w/w/o removal of ovaries _____
- ☐ Knee surgery _____
- ☐ Open heart surgery _____
- ☐ Pacemaker _____
- ☐ Plastic surgery (type) _____
- ☐ Removal of appendix _____
- ☐ Removal of gallbladder_____
- ☐ Removal of kidney _____
- ☐ Shoulder surgery _____
- ☐ Thyroid/Parathyroid _____
- ☐ Tonsillectomy _____
- ☐ Weight loss surgery _____
- ☐ Other _____
- ☐ None

Medications

List all prescription and non-prescription medications (including vitamins, supplements, over-the-counter, etc.):
Blood Thinners (e.g. Aspirin, Plavix, Warfarin): _____

Medications	Dosage

Preferred Pharmacy: _____

New Patient History Continued

Allergies

☐ Penicillin ☐ Sulfa ☐ Sutures ☐ Latex ☐ Tape ☐ Skin glue ☐ Contrast dye
☐ None ☐ Other: _____

Family Medical History

Place a check mark in the appropriate boxes to identify all illnesses/conditions which you know have occurred in your blood relatives. Do NOT include yourself.

Illness/Condition	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	Father	Mother	Brother	Sister
☐ Adopted/ Do not know family history								
Cancer-List type:	☐	☐	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐	☐	☐
Heart Trouble	☐	☐	☐	☐	☐	☐	☐	☐
Kidney trouble	☐	☐	☐	☐	☐	☐	☐	☐
Stroke/TIA	☐	☐	☐	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐	☐	☐	☐
Mental Illness	☐	☐	☐	☐	☐	☐	☐	☐
Anesthesia Complications	☐	☐	☐	☐	☐	☐	☐	☐
DVT/ Pulmonary embolism	☐	☐	☐	☐	☐	☐	☐	☐
Other:	☐	☐	☐	☐	☐	☐	☐	☐

Social History

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed
Occupation:_____ ☐ Full-time ☐ Part-time ☐ Retired
Are you involved with any of the following:
☐ Disability claim ☐ Worker's compensation ☐ Lawsuit
Number of pregnancies: _____ Number of living children: _____
Presently living alone? ☐ Yes ☐ No
Do you use tobacco? ☐ Yes ☐ No e-cigarettes? ☐Yes ☐ No If yes, how much?
Former smoker? ☐ Yes ☐ No
Do you drink alcohol? ☐ Yes ☐ No If yes, how much?
Do you use illicit drugs? ☐ Yes ☐ No If yes, how much?