Name:
DOB:

NEW PATIENT MEDICAL HISTORY FORM

Allergies:

ALLERGY	REACTION	SEVERITY

Medications:

MEDICATION	DOSAGE	INSTRUCTIONS

If you need more room to list medications, please attach the list on a blank sheet of paper.

Personal Medical History:

DISEASE/CONDITION	CURRENT	PAST	ADDITIONAL INFO
ALCOHOL/DRUG ABUSE **CIRCLE WHICH APPLY**			
ASTHMA			
CANCER			TYPE:
DEPRESSION			
ANXIETY			
BIPOLAR			TYPE:
SUICIDAL			
DIABETES			TYPE:
EMPHYSEMA (COPD)			
HEART DISEASE			
HIGH BLOOD PRESSURE			
LOW BLOOD PRESSURE			
HIGH CHOLESTEROL			
KIDNEY DISEASE			
HYPOTHYROIDISM			
HYPERTHYROIDISM			
MIGRAINE			
STROKE			
HEART ATTACK			

ADDITIONAL MEDICAL DIAGNOSIS:

SURGERIES: Please include a specific date and place if able.

SOCIAL HISTORY: Please check either yes or no and answer questions prompted in boxes.

	YES	NO
TOBACCO CIRCLE ONE: CIGARETTES, VAPE, CIGAR, DIP		
ALCOHOL # OF DRINKS/WEEK:		
MARIJUANA # OF DAYS/WEEK:		
RECRATIONAL DRUGS		

PROVIDERS/SPECIALSITS:

CARDIOLOGIST:

GASTEROENTEROLOGIST:

OB/GYN:

NEUROLOGIST:

PULMONARY:

OTHER:

Please indicate maternal or paternal side

FAMILY MEDICAL HISTORY:

DISEASE/CONDITION	FAMILY MEMBER(S)	ADDITIONAL INFORMATION
ALCOHOL/DRUG ABUSE **CIRCLE WHICH APPLY**		
ASTHMA		
CANCER		TYPE:
DEPRESSION		
ANXIETY		
BIPOLAR		TYPE:
SUICIDAL		
DIABETES		TYPE:
EMPHYSEMA(COPD)		
HEART DISEASE		
HIGH BLOOD PRESSURE		
LOW BLOOD PRESSURE		
HIGH CHOLESTEROL		
KIDNEY DISEASE		
HYPOTHYROIDISM		
HYPERTHYROIDISM		
MIGRANE		
STROKE		
HEART ATTACK		

ADDITIONAL MEDICAL DIAGNOSIS (FAMILY): Please include the family member(s)