NEW PATIENT MEDICAL HISTORY

NAME_____ DATE _____

Please answer these questions to the best of your knowledge. Your answers will help us provide the best possible medical care.

WHAT MEDICINES (PRESCRIPTION AND NON-PRESCRIPTION) DO YOU TAKE? _____

_____

WHAT MEDICINES ARE YOU ALLERGIC TO? _____

WHEN WAS YOUR LAST TETANUS SHOT? _____

Did a doctor ever tell you that you had an illness of:			**If YES, explain and give date(s):**
Cancer	NO	YES	
Nervous System (stroke, paralysis, pinched nerve, fainting, other)	NO	YES	
Eye	NO	YES	
Ear (hearing, dizziness, other)	NO	YES	
Lung (asthma, emphysema, clots in lung, pneumonia, other)	NO	YES	
High Blood Pressure	NO	YES	
High Cholesterol	NO	YES	
Heart (heart attack, angina, murmur, other)	NO	YES	
Stomach / Bowel (ulcer, hiatal hernia, colitis, other)	NO	YES	
Gallstones / Gallbladder	NO	YES	
Liver (hepatitis, cirrhosis, other)	NO	YES	
Male Organs (prostate, testicles, other)	NO	YES	
Female Organs / Breast (tubal pregnancy / infection, fibroids, abnormal PAP smear, other) # PREGNANCIES_____ # DELIVERIES_____ # MISCARRIAGES / ABORTIONS_____	NO	YES	
Kidney / Bladder (stones, infection, other)	NO	YES	
Sexually Transmitted Disease / V. D. (syphilis, chlamydia, gonorrhea, trichomoniasis, genital warts, HIV/AIDS)	NO	YES	
Arthritis (gout, rheumatoid, other)	NO	YES	
Mental or Emotional Problems (including counseling or medication for "nerves")	NO	YES	
Overuse of Alcohol or Drugs	NO	YES	
Diabetes / Thyroid	NO	YES	
Skin	NO	YES	
Blood (anemia, bleeding tendency, sickle cell, other)	NO	YES	
Illness / Hospitalization / Surgery (not mentioned above)	NO	YES	

Do you / have you used tobacco? No / Yes → Type _____, # per day _____, for how many years _____

Do you / have you used alcohol? No / Yes → Type _____, # per day _____, for how many years _____

_____

FOR STAFF USE ONLY: Reviewed By _____ Date_____