NEW PATIENT MEDICAL HISTORY

DEMOGRAPHICS			
Name:	DOB:	Age:	Sex:
Address:	City, State:	Zip:	
Pharmacy Name:	Pharmacy Telephone:		
Pharmacy Address:			

Allergies to Medications, X-Ray Dyes, or Other Substances	☐ **Yes** ☐ **No**
Name of medications or other substances	Reaction

CURRENT MEDICATION			
Drug name	Dose	Drug Name	Dose

PAST MEDICAL AND SURGICAL HISTORY		
Hospitalizations/Surgeries		
Month/Year	Illness or Operation	Hospital or Treating MD

FAMILY HISTORY					
ILLNESS	Mother	Father	Sibling	Grandparent	Date Diagnosed
Hypertension					
Heart Disease					
Diabetes					
Stroke					
Kidney Disease					
Bleeding Disorders					
Cancer (Type)__________					

SOCIAL HISTORY
☐Caffeine Daily
☐Tobacco Use ____ # Packs Per Day ☐Tobacco Use (Past) ____ Year Quit
☐Alcohol Use ____ # Drinks Per Day
☐Exercise ____ Times Per Week
☐Illicit Drug Use

PREVENTIVE HISTORY	WOMEN ONLY	MEN ONLY
Last colonoscopy:	Last Mammogram:	Last Prostate Exam:
Where/Physician	Last Bone Density:	Do you see a urologist? YES NO
Last Flu Vaccine:	Last Pap Smear:	Dr. Name
Pneumonia Vaccine:	Name of OB/GYN:	
Last Eye Exam: Doctor:		