NEW PATIENT MEDICAL HISTORY

NAME: _____ DATE OF BIRTH: _____ DATE: _____

1. ALLERGIES: Are you allergic to any medications? Allergies to: _____ _____

☐ NO KNOWN ALLERGIES _____ _____

_____ _____

2. PAST OR CURRENT ILLNESSES (please circle):

Ulcer ☐ Asthma ☐ Thyroid ☐ High blood pressure ☐ Heart attack ☐ Stroke ☐

GERD ☐ Migraines ☐ Hepatitis ☐ Family Violence ☐ Heart murmur ☐ Anemia ☐

Cancer ☐ Diabetes ☐ Dep ion ☐ Anxiety ☐ ADHD ☐ Bipolar Disorder ☐

HIV/AIDS ☐ Other (please list):

3. **SURGICAL HISTORY:** Please list any operations you've had, including tonsillectomy, appendix, hernias, tuba! ligations, with the year of the surgical procedure.

☐ NO OPERATIONS

	OPERATION	YEAR		OPERATION	YEAR
A.	_____	_____	D.	_____	_____
B.	_____	_____	E.	_____	_____
C.	_____	_____	F.	_____	_____

4. HOSPITALIZATIONS: Please tell us of any non-surgical hospitalizations you've had, including heart, lung, kidney, or other serious medical problems.

☐ NO HOSPITALIZATIONS

	PROBLEM REQUIRING HOSPITALIZATION	YEAR
A.	_____	_____
B.	_____	_____
C.	_____	_____

5. MEDICATIONS: Please tell us of all medications you are regularly taking (including blood pressure, diabetes, birth control, hormones, etc.)

[ ] Name of your local Pharmacy:

[ ] Street address of Pharmacy:

☐ NO MEDICATIONS

	MEDICATION	DOSE		MEDICATION	DOSE
A.	_____	_____	D.	_____	_____
B.	_____	_____	E.	_____	_____
C	_____	_____	F.	_____	_____

6. SMOKING: Do you smoke cigarettes?

YES ☐ **NO** ☐ If YES, how many packs a day? _____ At what age did you start smoking? _____

7. ALCOHOL INTAKE: How many cocktails, cans of beers, or glasses of wine do you drink per day?

☐ NO ALCOHOL EVER

	VERY RARELY	OCCASIONALLY	DAILY	TWO OR MORE PER DAY
COCKTAILS:	☐	☐	☐	☐
BEER:	☐	☐	☐	☐
WINE:	☐	☐	☐	☐

8. RECREATIONAL DRUG USE: marijuana, narcotics, cocaine, ecstasy, methamphetamines, etc?
YES☐ NO☐

9. PHYSICAL EXAM: When was your last complete physical, including EKG, blood sugar, cholesterol, urinalysis, etc.?

☐Never had one Year of last physical _____ Physician: _____

Physician Address: _____

10. FAMILY HISTORY (please note grandparents, parents, siblings or aunts/uncles):

Cancer	Diabetes	High Blood Pressure	Alcoholism	Heart Attack/Stroke	Depression/Anxiety

11. WOMEN'S HEALTH

When was the first day of your last period? _____ Last Pap Smear? _____

Have you ever had an abnormal pap smear? **YES☐ NO☐**

If Yes, did you have a colposcopy? **YES☐ NO☐**

Last Mammogram? _____

How may pregnancies have you had? _____ How may living children? _____ Abortions? _____

Miscarriages? _____