NEW PATIENT INFORMATION

Name: _____ Age: _____

Present Medications (Prescription & OTC): list name and dosage	DATE STARTED
1._____	_____
2._____	_____
3._____	_____
4._____	_____
5._____	_____
6._____	_____

Allergies to ANY Medications:	Medication Name	Reaction/Allergy
NONE_____	1._____	_____
	2._____	_____
	3._____	_____
	4._____	_____

Previous/Existing Medical Problems:	YES	NO	HOW LONG
Asthma	_____	_____	_____
Diabetes	_____	_____	_____
High Blood Pressure	_____	_____	_____
Heart Disease	_____	_____	_____
Elevated Cholesterol	_____	_____	_____
Other: _____	_____	_____	_____
Other: _____	_____	_____	_____

Previous Surgeries:	YES	NO	DATE
Gall Bladder	_____	_____	_____
Appendix	_____	_____	_____
Tonsillectomy	_____	_____	_____
Hysterectomy	_____	_____	_____
Other: _____	_____	_____	_____
Other: _____	_____	_____	_____

Major Accidents:	YES	NO	DATE
Head Trauma	_____	_____	_____
Major Bone Fracture	_____	_____	_____
Other: _____	_____	_____	_____
Other: _____	_____	_____	_____

Hospitalized for Other Reasons:	DATE
1. _____	_____
2. _____	_____
3. _____	_____

Have you ever had a Blood Transfusion? YES_____ NO_____
If YES, YEAR_____

LAST TETANUS SHOT Date:_____

Do you have any TATTOOS? YES_____ NO_____
If YES, Date of OLDEST Tattoo _____

CONTINUE ON BACK SIDE – OVER

FAMILY HISTORY PLEASE FILL OUT COMPLETED & BE SPECIFIC

MOTHER: Alive_____ Age_____ Deceased_____ Age Deceased_____
Medical Issues: Cause of Death:_____

1. _____
2. _____
3. _____

FATHER: Alive_____ Age_____ Deceased_____ Age Deceased_____
Medical Issues: Cause of Death:_____

1. _____
2. _____
3. _____

BROTHERS Ages:	Medical Problems	SISTERS Ages:	Medical Problems
____	_____	____	_____
____	_____	____	_____
____	_____	____	_____

Any Family History of:	YES	NO	WHO
Colon Cancer Dx age: _____	_____	_____	_____
Colon Polyps Dx age: _____	_____	_____	_____
Breast Cancer Dx age: _____	_____	_____	_____
Ovarian Cancer	_____	_____	_____
Osteoporosis/Osteopenia	_____	_____	_____
Prostate Cancer	_____	_____	_____
ETOH Abuse (Alcohol)	_____	_____	_____
Anxiety/Panic Disorder	_____	_____	_____
Depression	_____	_____	_____
Bipolar Disease	_____	_____	_____
Suicide or Suicidal Thoughts	_____	_____	_____
Other: _____	_____	_____	_____
Other: _____	_____	_____	_____

SOCIAL HABITs: Tobacco – YES _____ NO _____ QUIT _____ / Date: _____
If YES, How Long? _____ / PPD: _____
Alcohol –– YES _____ NO _____
If YES, How Often? _____ How much?_____
Caffeine -- YES _____ NO _____
If YES, Amount Daily? _____

OCCUPATION: _____ Retired _____ / Date _____

MARITAL STATUS: Married _____ / Yrs. _____ Divorced _____ / Yr. _____
Widowed _____ / Yr. _____ Separated _____ Single _____

CHILDREN: How Many? _____

WOMEN ONLY: Menstrual History
Periods: Age of 1st period _____ Date of Most Recent Period _____
How many days do they last? _____
Birth Control: YES _____ NO _____ What Type _____
If Post-Menopausal – Date of LAST Period _____ Hormone Therapy: Dates _____
# of Pregnancies _____
Deliveries: Vaginal _____ C-Sections _____ Miscarriages _____ Abortions _____
History of Abnormal PAP: YES _____ NO _____ If Yes, Treatment: _____