New Patient Medical History, Medications, and Allergies

Patient Name: ______________________________ **DOB:** ____________ **Date:** ______________

Patient Medical History (Check All That Apply)

□ Alcoholism	□ Cancer	□ Gout	□ Liver Disease	□ Skin Disorder
□ Allergies	□ COPD	□ Heart Disease	□ Lung Disease	□ Stomach Ulcer
□ Anemia	□ Diabetes - I or II	□ Heart Problems	□ Measles	□ Thyroid Disorder
□ Anxiety	□ Depression	□ Hepatitis - A/B/C	□ Migraines	□ Tuberculosis
□ Arthritis	□ Eating Disorder	□ Hypertension	□ Osteoporosis	□ Other:
□ Asthma	□ Epilepsy	□ High Cholesterol	□ Pneumonia	
□ AIDS/HIV	□ Glaucoma	□ Kidney Disease	□ Stroke	

List medications you are currently taking. Including prescriptions, over-the-counter drugs, and supplements.

Medication Name	Dose	Frequency

If more space is needed for medications, write on back of page.

Allergies/Reaction	Surgeries/Dates	Hospitalizations

Family History (Specify Maternal/Paternal)

Diabetes Yes___No___Who:	Mental Health Yes___No___Who:
Hypertension Yes___No___Who:	Cancer Yes___No___Who:
Heart Disease Yes___No___Who:	Other Yes___No___Who:
Stroke Yes___No___Who:	

Do you/Have you: (Circle one, explain if yes) **Height:** __________ **Weight:** __________

Smoke: Yes No Cigarettes Vape Cigars Chewing Tobacco Recreational Drugs How much/often: ____________________

Drink Caffeine: Yes No Amount/Kind:________________ **Occupation:** ____

Drink Alcohol: Yes No Rarely Socially Occasionally Daily **Occupational Exposure (Circle All That Apply)**

Traveled Outside The USA: Yes No Where:____________ Bodily Fluids Smoke/Dust Noise Asbestos Solvents

______________________________ ______________

Patient Signature/ Parent or Legal Guardian **Date**