New Patient Medication, Allergies and Surgical History

Patient Name: ________________________________ Patient DOB: ________________ Date: _____________

List medications you are currently taking. Including prescriptions, over-the-counter drugs, as well as any supplements you use regularly.

Medication Name	Frequency	Dosage	Purpose

List any medical conditions			Family History		
Diabetes	**Yes** ______	**No** _______	**Yes**____	**No** _____	**Who**___________________
Hypertension	**Yes** ______	**No** _______	**Yes**____	**No** _____	**Who**___________________
Heart Disease	**Yes** ______	**No** _______	**Yes**____	**No** _____	**Who**___________________
Stroke	**Yes** ______	**No** _______	**Yes**____	**No** _____	**Who**___________________
Mental Health	**Yes** ______	**No** _______	**Yes**____	**No** _____	**Who**___________________
Cancer	**Yes** ______	**No** _______	**Yes**____	**No** _____	**Who**___________________
Other ______________	**Yes** ______	**No** _______	**Yes**____	**No** _____	**Who**___________________

Surgeries	Dates

Allergies	Reaction

Height: ___________________________________ **Weight:** __________________________
Do you smoke: Yes __________ No: ___________ **If Yes, how often/much:** _________________________
Do you drink caffeine: Yes _________ No _________ **Amount/Kind:** ______________________________
Do you drink Alcohol? No __________ Rarely__________ Socially__________ Occasionally____________
Have you recently traveled out of the country? Yes ______ No _______ Locations ________________
Occupation: ____
Any occupational exposure to: Body fluids ____ Smoke ____ Noise ___ Asbestos ____ Solvents ____

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