NEW PATIENT MEDICAL HISTORY FORM

Patient Name: ______________________________ **Age:** _____ **Date:** ____ /____/________
DOB ____ /____/________ **SSN:** __ __ __ - __ __ - __ __ __ __

1) **Reason for visit:** ____
2) **Past Medical History:**

☐ Diabetes ☐ Thyroid disease ☐ Liver disease ☐ High blood pressure
☐ Stroke ☐ Kidney disease ☐ Lung disease ☐ Heart disease
☐ Anemia ☐ High cholesterol ☐ Cancer:__________________________________

3) **Past Surgical History:**

☐ Tonsils ☐ Hysterectomy ☐ Thyroid surgery (Year __________)
☐ Gallbladder ☐ Bariatric/weight loss ☐ Parathyroid surgery (Year ______________)
☐ Appendix ☐ Hernia ☐ Heart surgery/CABG/stent (Year __________)

4) **Medications:**

a)______________________ b) ______________________ c) ______________________
d) ______________________ e) ______________________ f) ______________________
g) ______________________ h) ______________________ i) ______________________
j) ______________________ k) ______________________ l) ______________________
m) ______________________ n) ______________________ o) ______________________

5) **Allergies:** ____
6) **Family History:**

a) Father:________________________________ b) Mother:_______________________________
c) Brother:________________________________ d) Sister:_________________________________
e) Other family ____

7) **Home History:**

☐ Single ☐ Married/Partner ☐ Divorced/Separated ☐ Widowed

8) **Occupation/Employment:**

☐ Full-time ☐ Part-time ☐ Retired ☐ Unemployed ☐ Disabled

9) **Social History:**

Do you smoke? ☐ YES ☐ NO ☐ Packs per day (_______________)
☐ Cigarettes ☐ Cigars ☐ Vape ☐ Former (Year quit_____________)
Do you drink alcohol? ☐ YES ☐ NO ☐ Drinks per week (_____________)
☐ Wine ☐ Beer ☐ Hard liquor ☐ Former (Year quit _____________)
Do you use illicit drugs? ☐ YES ☐ NO ☐ Former (Year quit _____________)
Do you exercise: ☐ YES ☐ NO
What activity? ____________________ How many minutes? ______________
☐ Everyday ☐ 1-2 x week ☐ 2-3 x week ☐ 3-4 x week ☐ Seldom/never

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