

Welcome to Our Practice!
As a new patient, please fill out the information found below to the best of your ability.

Patient Name _____ Date of Birth _____ Today's Date _____

Patient Medical History:

Have you ever had the following (check "no" or "yes". Leave blank if uncertain):

Measles	_No_Yes	Tuberculosis	_No_Yes	Stroke	_No_Yes
Mumps	_No_Yes	Diabetes	_No_Yes	Hepatitis	_No_Yes
Chickenpox	_No_Yes	Cancer	_No_Yes	Ulcer	_No_Yes
Whooping Cough	_No_Yes	Polio	_No_Yes	Kidney disease	_No_Yes
Scarlet Fever	_No_Yes	Glaucoma	_No_Yes	Thyroid disease	_No_Yes
Diphtheria	_No_Yes	Hernia	_No_Yes	Bleeding tendency	_No_Yes
Smallpox	_No_Yes	Blood or	_No_Yes	Any other disease	_No_Yes
Pneumonia	_No_Yes	plasma transfusions		(please list): _____	
Rheumatic Fever	_No_Yes	Back Trouble	_No_Yes		
Heart Disease	_No_Yes	High or low	_No_Yes		
		blood pressure			
Venereal Disease	_No_Yes	Hemorrhoids	_No_Yes		
Anemia	_No_Yes	Asthma	_No_Yes		
Bladder Infection	_No_Yes	Hives or eczema	_No_Yes		
Epilepsy	_No_Yes	Aids or HIV+	_No_Yes		
Migraine headaches	_No_Yes	Infectious mono	_No_Yes		
		Bronchitis	_No_Yes		
		Date of last chest x-ray: _____			
		Mitral Valve Prolapse	_No_Yes		

Medicine, food, or environmental
ALLERGIES (Please list): Yes / No

Previous Hospitalizations/Surgeries/Serious Illnesses When Hospital, city, state
 (include pregnancies) _____

Pharmacy used _____

Medications (Include nonprescription, supplements): _____

Patient Social History:

Marital status: _Single _Married _Domestic Partner _Separated _Divorced _Widowed
 Who lives with you? _____
 Use of alcohol: _Never _Rarely _Moderate _Daily / Average # of drinks per week _____
 Use of tobacco: _Never _Previously, but quit: _____ Current packs/day _____
 Use of drugs _Never _Type/frequency: _____
 Excessive exposure
 at home or work to: _Fumes _Dust _Solvents _Airborne particles _Noise
 Occupation/hours worked: _____
 Do you do testicular or breast exams? _____ What exercise do you do regularly? _____
 Do you use sunscreen? _____ Date of last eye exam _____ Last dental exam _____

Family Medical History:

	Age	Diseases	If deceased, cause of death
Father	_____	_____	_____
Mother	_____	_____	_____
Siblings	_____	_____	_____
Spouse	_____	_____	_____
Children	_____	_____	_____