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
		Glaucoma	__No__Yes	Thyroid disease	__No__Yes
Scarlet Fever	__No__Yes	Hernia	__No__Yes	Bleeding tendency	__No__Yes
Diphtheria	__No__Yes	Blood or	__No__Yes	Any other disease	__No__Yes
Smallpox	__No__Yes	plasma transfusions		(please list):_____	
Pneumonia	__No__Yes	Back Trouble	__No__Yes		
Rheumatic Fever	__No__Yes	High or low	__No__Yes	Medicine, food, or environmental	
Heart Disease	__No__Yes	blood pressure		**ALLERGIES** (Please list):Yes / No	
		Hemorrhoids	__No__Yes		
Venereal Disease	__No__Yes	Asthma	__No__Yes		
Anemia	__No__Yes	Hives or eczema	__No__Yes		
Bladder Infection	__No__Yes	Aids or HIV+	__No__Yes		
Epilepsy	__No__Yes	Infectious mono	__No__Yes		
Migraine headaches	__No__Yes	Bronchitis	__No__Yes		
		Date of last chest x-ray:_____			
		Mitral Valve Prolapse	__No__Yes		

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	_____	_____	_____
	_____	_____	_____