

New Patient Health History – Adult

Name _____ Date of Birth _____ Today's Date _____

Current Medical Concerns (what you would like to talk about today):

1. (most important) _____

2. _____

Please list any allergies you have to medications:

Name of Med Reaction

Please list any medications that you currently take, including Over the Counter Medications, Herbal Supplements, or Vitamins (please write on back of page if needing additional space):

Name of Med Dose Directions (How often you take it)

Have you received the following immunizations (shots)? If yes, please indicate the approximate year received:

Flu Shot: Yes No Year _____ Tetanus/Diphtheria: Yes No Year _____ Hepatitis A: Yes No Year _____

Shingles: Yes No Year _____ Pneumonia Shot: Yes No Year _____ Hepatitis B: Yes No Yr _____

MMR: Yes No Year ___ Polio: Yes No Year ___ Other: _____ Year _____

WOMEN: Is there a chance you are pregnant? Yes No

Have you been pregnant before? Yes No (How many times?) _____

When was your last menstrual period? _____

Have you ever had surgery? Yes No If YES, please list them (include the year if possible):

Any hospitalizations? Yes No If YES, please list them (include the year if possible):

Have you ever had any other serious injuries? Yes No If YES, please list them (include the year if possible):

Have you had any of these TESTS? If YES, please indicate when:

Colonoscopy: Yes No Year _____ Bone Density Test: Yes No Year _____

Pap Smear: Yes No Year _____ Mammogram: Yes No Year _____

Heart Testing/Stress Test: Yes No Year _____

Do you or have you ever smoked tobacco? Yes No

How Many Years did you smoke tobacco? _____

Do you use or have you used other forms of tobacco, like chewing tobacco? Yes No

Do you use e-cigarettes (vape)? Yes No

FAMILY HEALTH HISTORY

Are you adopted? Yes No (If NO, please complete section below) P=Paternal M=Maternal

	Mother	Father	Grandma	Grandpa	Brother	Sister	Aunt	Uncle
ADHD								
Alzheimer's Disease								
Alcoholism								
Aneurysm								
Anxiety								
Arthritis								
Asthma								
Bipolar Disorder								
Cancer								
Depression								
Diabetes								
Emphysema/COPD								
Heart Attack								
Hereditary Disorder								
High Cholesterol								
High Blood Pressure								
Kidney Disease								
Liver Disease								
Migraines								
Osteoporosis								
Schizophrenia								
Seizures/Epilepsy								
Skin Cancer								
Stroke								
Substance Abuse								
Sudden Cardiac Death								
Thyroid Disorder								

PERSONAL HEALTH HISTORY

ADHD or ADD	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Endometriosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Alcoholism	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Fibromyalgia	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Allergies/Hay fever	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Gout	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Anemia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	GYN Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Anesthesia Complications	<input type="checkbox"/> Yes	<input type="checkbox"/> No	HIV	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Anxiety Disorder or Recurrent Anxiety	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Heart Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Arthritis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Hepatitis C	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes	<input type="checkbox"/> No	High Blood Pressure/Hypertension	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Autism Spectrum Disorder	<input type="checkbox"/> Yes	<input type="checkbox"/> No	High Cholesterol	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Bipolar	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Kidney Stones	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Birth Defects or Inherited Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Kidney or Bladder Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Blood Transfusion	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Liver Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Migraines	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Chicken Pox	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Muscle, Joint, or Bone Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Clotting Problems/bleed too much	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Osteoporosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Depression	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Reflux/GERD	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Developmental or Behavioral Disorders	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Seizures/Epilepsy	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Diabetes or Pre-Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Schizophrenia	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Diverticulitis/Diverticulosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Skin problems (Rashes/Changing Moles)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Domestic Violence	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Stomach Ulcers or Swallowing Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Ear Infections - Chronic	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Stroke or TIA	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Ear or Hearing Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Substance Abuse	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Eating Disorder like Anorexia or Bulimia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Thyroid Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Eczema	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Tuberculosis or Positive TB Test	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Emphysema/COPD/Chronic Bronchitis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Vision or Eye Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No
			Other:	<input type="checkbox"/> Yes	<input type="checkbox"/> No