NEW PATIENT HEALTH HISTORY FORM

Patient Name: _____ **Birth date:** ___/___/___ **Date:** ___/___/___

Referring Physician: _____ Address: _____

Pharmacy Name: _____ Phone Number: _____-_____-_____

Reason for today's visit: _____

Please describe this problem: _____

_____

PRIOR SURGERIES	CURRENT/ PRIOR ILLNESSES/ INJURIES

Please list ALL medications (prescription and non- prescription) that you take. (Include herbal remedies, vitamins, over-the-counter, street drugs, prescriptions etc.)

MEDICATION	DOSAGE	MEDICATION	DOSAGE

Do you take any blood thinning products such as **Vitamin E, Plavix, Coumadin, or Aspirin?** ☐ **NO** ☐ **YES**

Do you have any food, environmental, or drug allergies? ☐ **NO** ☐ **YES** (Please explain below)

ALLERGY	TYPE	REACTION

Do you smoke? ☐ **NO** and Never have ☐ **YES** (Please explain below)

TYPE OF SMOKING (cigarette, pipe marijuana, chew, etc.)	HOW MUCH	HOW LONG

Do you drink alcohol? ☐ **NO** and Never have ☐ **Socially Only** ☐ **Daily** ☐ **Beer/ Wine** ☐ **Hard Liquor**

Occupation: _____ Hand Dominance: ☐ **RIGHT** ☐ **LEFT**

Please describe any family health issue below:

FAMILY HISTORY	GOOD/ NONE	UNKNOWN	ILLNESSES/ REASON FOR DEATH
MOTHER			
FATHER			
SIBLING(S)			
OTHER HEREDITARY ILLNESS			

Patient Signature: _____ **Date:** ___/___/___

Physician Signature: _____ **Date Reviewed:** ___/___/___

HEALTH HISTORY FORM 2

Do you have or have you ever had any of the following:

Symptoms/ Illness	NO	YES, Explain	Symptoms/ Illness	NO	YES, Explain
Constitutional			**Skin**		
Fever or Chills			Breast Abnormalities		
Weight Loss			Nipple Discharge		
Hematologic			**Last Mammogram**		**Date: ___/___/___**
Hepatitis			Changes in Moles		
HIV/ Other Blood Diseases			Lesions		
Bleeding Disorders			Rashes		
Endocrine			History of Keloids		
Thyroid Problems			**Neurological**		
Diabetes			Neurological Problems		
Musculoskeletal			Headaches		
Arthritis			**GENITOURINARY**		
Mobility/ Joint Problems			Genital or Oral Herpes		
GASTROINTESTINAL			S.T.D.'s		
Constipation			Blood in Urine		
Diarrhea			Urinary Tract Infection		
Blood in Stool			Problems Urinating		
Nausea/ Vomiting			Prostate Problems		
Liver Problems			Kidney Problems		
CARDIOVASCULAR			**Eyes**		
Heart Problems			Vision Problems		
Deep Vein Thrombosis/ DVT			**ENT**		
Blood Clots in Lungs/ Legs			Hearing Problems		
High Blood Pressure			Sinus Problems		
RESPIRATORY			**PSYCHIATRIC**		
Asthma			Mood Swings		
Sleep Apnea			Anxiety/ Depression		

Please list any other conditions/ illnesses not indicated above: _____

_____

To the best of my knowledge, this information is complete and correct. I understand that it is my responsibility to inform my doctor if there are any changes to my health.

Patient Signature: _____ **Date:** ___/___/___

Physician Signature: _____ **Date Reviewed:** ___/___/___