Family Medical New Patient Medical History Form

(Please complete and bring with you to your first appointment)

Name:_____ **Date of Birth:**_____

☐ **NO ALLERGIES**

ALLERGY	ALLERGIC REACTION

MEDICATIONS *(please list all)*	DOSE	TIMES PER DAY

Your Medical History: *(Please circle any condition that applies to you)*

Cancer	Heart Attack	High Blood Pressure	High Cholesterol
Diabetes	Joint Pain	History of Fractures	Blood Clots
Asthma	Shortness of Breath	Migraine Headaches	Depression
Skin issues	Eye Disease	Hearing Issues	Other: _____

SURGERIES	DATE (YEAR)	LOCATION/FACILITY

SPECIALISTS	PROVIDER / FACILITY NAME	DATE OF LAST VISIT
CARDIOLOGY		
GASTROENTEROLOGIST		
—> COLONOSCOPY		***Date of last colonoscopy:***
OB/GYN		
NEUROLOGY		
PULMONOLOGY		
ENDOCRINOLOGY		
Other:		

VACCINE DATES: Tetanus / Tdap _____ TB Test_____ Shingles _____

Pneumonia _____ Hepatitis B _____ **Date of last Physical Exam:** _____

FEMALE PATIENTS ONLY: *(Please skip this section if the questions do not apply to you)*

Total number of pregnancies: _____ Number of Births: _____ Date of LMP:_____

Date of last Pap Smear: _____ Results: _____

Are you using birth control currently? _____ Last bone density scan: _____

Date of Last Mammogram: _____ Results: _____

Do you have a Health Care Proxy? YES / NO **Do you smoke?** YES / NO *How often:* _____

Do you drink alcohol? YES / NO *Number of times per week:* _____

✓ ***Check all that apply*** ***Note first name and year of birth:***	Alcohol/ Drug Abuse	Asthma	Cancer	Emphysema (COPD)	Mental Health Issues	Hyperlipidemia	Diabetes	Early Death	Heart Disease	High Cholesterol	High Blood Pressure	Kidney Disease	Stroke (Age: ____)	Thyroid Disease	Migraines	Other: _____	**HEALTHY**
Mother:																	
Father:																	
Mat Grandmother:																	
Mat Grandfather:																	
Pat Grandmother:																	
Pat Grandfather:																	
Sibling:																	
Sibling:																	
Sibling:																	
Sibling:																	
Child:																	
Child:																	
Child:																	
Child:																	

Patient Signature: _____ **Date:** _____

Family Medical Provider Signature: _____ **Date:** _____