The Doctor's Office - New Patient History form

Patient Name			**Date of Birth**		**Today's Date**	
Gender:			Last menstrual period (if applicable):			
Allergies:						
Medications and supplements						
Medical History (circle all that apply)	Abnormal Heart Rhythm	ADHD	Allergies	Anemia	Anxiety	Arthritis
	Asthma	Bipolar disorder	Bladder problems	Bleeding problems	Cancer (type):	
	COPD	Crohn's disease	Dementia	Depression	Diverticulosis	DVT (Blood Clot)
	Frequent headaches	GERD	Glaucoma	Heart attack	Hiatal Hernia	High blood pressure
	Incontinence	Kidney stones	Kidney disease	High cholesterol	HIV/AIDS	Hepatitis
	Irritable Bowel Syndrome (IBS)	Lupus	Liver disease	Macular degeneration	Migraines	Neuropathy
	Osteopenia	Parkinson's disease	Peripheral vascular disease	Psoriasis	Pulmonary embolism	Rheumatoid arthritis
	Seizure disorder	Sleep apnea	Stomach ulcer	Stroke	Hypothyroidism (low thyroid)	Hyperthyroidism (high thyroid)
	Ulcerative colitis	Heart disease	Osteoporosis	Alcoholism	Diabetes: 1 or 2	
	Other:					
Surgeries and date performed:						
Family History: (Circle all that apply)	Father:	Age at Death (if applicable):				
	Alcoholism	Anemia	Asthma	Arthritis	Bipolar disorder	Cancer
	COPD	Dementia	Depression	Diabetes: 1 or 2	DVT (Blood clot)	Heart disease
	High cholesterol	High blood pressure	Kidney disease	Migraines	Osteoporosis	Stroke
	Thyroid disorder	Other:				
	Mother:	Age at Death (if applicable):				
	Alcoholism	Anemia	Asthma	Arthritis	Bipolar disorder	Cancer
	COPD	Dementia	Depression	Diabetes: 1 or 2	DVT (Blood clot)	Heart disease
	High cholesterol	High blood pressure	Kidney disease	Migraines	Osteoporosis	Stroke
	Thyroid disorder	Other:				

Patient Name			**Date of Birth**		**Today's Date**	
Health issues in siblings and children:						
Education Level (Circle one)	High school graduate	GED	Some college, no degree	Vocational school	Associate's Degree	Bachelor's Degree
	Quit (Approximate date):	Professional school (MD, DVM, JD, DDS, etc.)	PhD	No school	Grade:	
Living situation (Circle one)	At home alone	With both parents	With one parent	With children	At home with spouse	Nursing home
	Homeless	Other:				
Employment (Circle one):	Employed	Unemployed	Disabled	Retired	Student	
	Current or former occupation:					
Tobacco:	Current use	Never used	Quit (Approximate date):		Packs per day:	
Alcohol:	Current use	Never used	Quit (Approximate date):		Drinks per week:	
Recreational drugs:	Current use	Never used	Quit (Approximate date):		Type:	
Sexually active?:	Never	>1 year ago	Recently	Number of lifetime partners:		
Current birth control:	Pills/rings	Condoms	Shots	Arm implant	IUD	None
History of sexually transmitted infections (circle all that are applicable)	Gonorrhea	Chlamydia	HPV	Herpes	Trichomonas	
	Are there religious issues that affect your healthcare:			No	Yes	
	Are there financial issues that affect your care			No	Yes	
	Are you safe at home?		No	Yes		
Other Healthcare Providers that you see:						