



## NEW PATIENT MEDICAL HISTORY

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

<b>Name</b> <i>(Last, First, M.I.):</i>	<input type="checkbox"/> M	<input type="checkbox"/> F	<b>DOB:</b>
<b>Marital status:</b> <input type="checkbox"/> Single <input type="checkbox"/> Partnered <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed			
<b>Previous or referring doctor:</b>		<b>Date of last physical exam:</b>	

### PERSONAL HEALTH HISTORY

**List any medical problems, diagnoses and diseases:**

#### Surgeries

Year	Reason	Hospital

#### List all other doctors you see and their specialty


#### List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers

Name the Drug	Strength	Frequency Taken

#### Allergies to medications

Name the Drug	Reaction You Had

## HEALTH HABITS AND PERSONAL SAFETY

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.

<b>Alcohol</b>	Do you drink alcohol?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	If yes, what kind?		
	How many drinks per week?		
<b>Tobacco</b>	Do you use tobacco?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	<input type="checkbox"/> Cigarettes – pks./day	<input type="checkbox"/> Chew - #/day	<input type="checkbox"/> Pipe - #/day
	<input type="checkbox"/> # of years	<input type="checkbox"/> Or year quit	

## FAMILY HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
<b>Father</b>			<b>Children</b>	<input type="checkbox"/> M	
				<input type="checkbox"/> F	
<b>Mother</b>				<input type="checkbox"/> M	
			<input type="checkbox"/> F		
<b>Sibling</b>	<input type="checkbox"/> M			<input type="checkbox"/> M	
	<input type="checkbox"/> F			<input type="checkbox"/> F	
	<input type="checkbox"/> M			<input type="checkbox"/> M	
	<input type="checkbox"/> F			<input type="checkbox"/> F	
	<input type="checkbox"/> M				
	<input type="checkbox"/> F			<b>Grandmother</b> <i>Maternal</i>	
	<input type="checkbox"/> M			<b>Grandfather</b> <i>Maternal</i>	
	<input type="checkbox"/> F			<b>Grandmother</b> <i>Paternal</i>	
<input type="checkbox"/> M			<b>Grandfather</b> <i>Paternal</i>		
<input type="checkbox"/> F					

Date of last mammogram: (Women)

Number of pregnancies \_\_\_\_\_ Number of live births \_\_\_\_\_

Date of last pap and rectal exam?

Date of last prostate and rectal exam? (men)

Yes  No

Check if you are experiencing any symptoms in the following areas to a significant degree and briefly explain.

<input type="checkbox"/> Skin	<input type="checkbox"/> Chest/Heart	<input type="checkbox"/> Recent changes in:
<input type="checkbox"/> Head/Neck	<input type="checkbox"/> Back	<input type="checkbox"/> Weight
<input type="checkbox"/> Ears	<input type="checkbox"/> Intestinal	<input type="checkbox"/> Energy level
<input type="checkbox"/> Nose	<input type="checkbox"/> Bladder	<input type="checkbox"/> Ability to sleep
<input type="checkbox"/> Throat	<input type="checkbox"/> Bowel	<input type="checkbox"/> Other pain/discomfort:
<input type="checkbox"/> Lungs	<input type="checkbox"/> Circulation	