

**NEW PATIENT MEDICAL HISTORY  
AND MEDICATIONS**



Patient Name: \_\_\_\_\_ DOB (Date of Birth): \_\_\_\_\_

CURRENT HEALTH HISTORY			
<b>IMPORTANT: What medical or health concern(s) would you like to discuss with the provider at your first visit?:</b>			
<b>Who was your previous primary care provider (PCP)?</b>			
<b>When were you last seen?</b>		<b>When was your most recent complete physical exam?</b>	
<b>Please list any current diagnosis(es) and/or medical problem(s):</b>			
Diagnosis/Medical Problem	Date Diagnosed	Diagnosis/Medical Problem	Date Diagnosed
1.		4.	
2.		5.	
3.		6.	
<b>Any personal history of cancer?</b>			

ALLERGIES OR UNUSUAL REACTIONS	
Medication(s)	Reaction

LIST OF CURRENT MEDICATIONS			
Please list <b>ALL medications</b> you are <b>CURRENTLY taking</b> (INCLUDING Over-The-Counter (OTC) medications) and <b>BRING ALL MEDICATIONS</b> with you including dosage and frequency to your Initial Medical Exam:			
Medication	Dose	How Often	Prescribing Clinic or provider

**SURGICAL HISTORY**

Please list any surgeries (appendix removal, hysterectomy, etc.) you have had below:

Surgery	Date of Surgery	Surgery	Date of Surgery
1.		4.	
2.		5.	
3.		6.	

**WOMEN ONLY**

Who is your OBGYN?

When were you last seen?

When was your most recent pap smear?

When was your most recent mammogram?

Date of last menstrual period?	Could you be pregnant?	Method of birth control used?	Number of pregnancies?	Number of life births?	Number of miscarriages?	Number of abortions?

Is there anything else you would like to disclose?

**LIFESTYLE HABITS**Do you use tobacco?  Yes  No If yes, what age did you start?: \_\_\_\_\_

Tobacco product(s) do you use?: \_\_\_\_\_ Frequency?: \_\_\_\_\_

Are you a former smoker?  Yes  No If yes, start age: \_\_\_\_\_ quit age: \_\_\_\_\_Do you drink alcohol?  Yes  No

If yes, how many drinks do you consume per week?: \_\_\_\_\_

Exercise Frequency:

How many minutes per week do you do cardio?: \_\_\_\_\_

How many minutes per week do you do strength training?: \_\_\_\_\_

How many meals do you typically eat out per week?: \_\_\_\_\_ How many meals per week are fast food?: \_\_\_\_\_

Is there anything else you would like to disclose?

**FAMILY HISTORY**

Please indicate any family history of illnesses below where applicable:

FAMILY HISTORY	BIRTH DATE	IF PASSED,		PRESENT CONDITION OR CAUSE OF DEATH
		DATE OF DEATH	AGE AT DEATH	
Mother				
Father				
Other Family: _____				
Other Family: _____				

**PREFERRED PHARMACY**

Please indicate what pharmacies you use and make a note to indicate any special instructions:

Pharmacy Name	Location or Phone Number	Notes

I certify that the information on this form is true and correct to the best of my knowledge.

Signature \_\_\_\_\_

Date \_\_\_\_\_