Date of visit: _____

Name: _____ Birthday: _____ Age: _____ Gender: _____

New Patient Medical Form

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Your answers on this form will help your provider understand your medical concerns and conditions better. If you are uncomfortable with any question, do not answer it. Best estimates are fine if you cannot remember specific details.Thank you!

Circle one on below question, if not normal please explain:

Date last full physi
Date last prostate exam (males):_____ Normal vs. Not normal_____
Date last PAP and pelvic exam (females):_____ Normal vs. Not normal_____
Date last mammogram (females):_____ Normal vs. Not normal_____
Date last DEXA or bone imaging (females):_____ Normal vs. Not normal_____

Surgeries and Hospitalizations with Dates

_____

_____

Allergies (drugs, food, environmental)_____

PERSONAL MEDICAL HISTORY:

Please check (?) if you have had any of the following medical problems

	Heart disease/ Heart attack		**Diabetes**		Depression/anxiety
	Bleeding/clotting problem		High cholesterol		Seizures
	Cancer (Malignancy)		Thyroid problem		OBGYN Problem
	High blood pressure		Hepatitis		**Pacemaker**

FAMILY HISTORY (Note: members of family affected)

	Heart disease/ Heart attack		Diabetes		Depression/anxiety
	Bleeding/clotting problem		High cholesterol		Seizures
	Cancer (Malignancy)		Thyroid problem		Breast Cancer
	High blood pressure		Hepatitis		Allergies/Asthma

SOCIAL HISTORY Please check (?) if you have had any of the following

1. ( ) Nicotine/Smoke — How many pack a day? _____Since when_____
2. ( ) Alcohol — How many glass a day/Week?_____
3. ( ) Caffeine — How many cup a day?_____
4. ( ) Soda — How many cans a day?_____

Need help for Quitting?_____