# NEW PATIENT HEALTH HISTORY FORM

Patient Name:

Birth date: / /

Date: / /

Referring Physician: Address:

Pharmacy Name: Phone Number: - -

Reason for today’s visit:

Please describe this problem:

|  |  |
| --- | --- |
| **PRIOR SURGERIES** | **CURRENT/ PRIOR ILLNESSES/ INJURIES** |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |

Please list ALL medications (prescription and non- prescription) that you take. (Include herbal remedies, vitamins, over- the-counter, street drugs, prescriptions etc.)

|  |  |  |  |
| --- | --- | --- | --- |
| **MEDICATION** | **DOSAGE** | **MEDICATION** | **DOSAGE** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

Do you take any blood thinning products such as Vitamin E, Plavix, Coumadin, or Aspirin? NO YES





Do you have any food, environmental, or drug allergies? NO  YES (Please explain below)

|  |  |  |
| --- | --- | --- |
| **ALLERGY** | **TYPE** | **REACTION** |
|  |  |  |
|  |  |  |

Do you smoke?  NO and Never have YES (Please explain below)

|  |  |  |
| --- | --- | --- |
| **TYPE OF SMOKING** (cigarette, pipe marijuana, chew, etc.) | **HOW MUCH** | **HOW LONG** |
|  |  |  |
|  |  |  |

Do you drink alcohol? NO and Never have Socially Only Daily Beer/ Wine Hard Liquor

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Occupation: Please describe any family health issue below:

|  |  |  |  |
| --- | --- | --- | --- |
| **FAMILY HISTORY** | **GOOD/ NONE** | **UNKNOWN** | **ILLNESSES/ REASON FOR DEATH** |
| MOTHER |  |  |  |
| FATHER |  |  |  |
| SIBLING(S) |  |  |  |
| OTHER HEREDITARY ILLNESS |  |  |  |

Hand Dominance: RIGHT LEFT

Patient Signature: Date: / /

Physician Signature: Date Reviewed: / /

# HEALTH HISTORY FORM 2

Do you have or have you ever had any of the following:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Symptoms/ Illness** | **NO** | **YES, Explain** | **Symptoms/ Illness** | **NO** | **YES, Explain** |
| **Constitutional** | | | **Skin** | | |
| Fever or Chills |  |  | Breast Abnormalities |  |  |
| Weight Loss |  |  | Nipple Discharge |  |  |
| **Hematologic** | | | **Last Mammogram Date: / /** | | |
| Hepatitis |  |  | Changes in Moles |  |  |
| HIV/ Other Blood Diseases |  |  | Lesions |  |  |
| Bleeding Disorders |  |  | Rashes |  |  |
| **Endocrine** | | | History of Keloids |  |  |
| Thyroid Problems |  |  | **Neurological** | | |
| Diabetes |  |  | Neurological Problems |  |  |
| **Musculoskeletal** |  |  | Headaches |  |  |
| Arthritis | | | **GENITOURINARY** | | |
| Mobility/ Joint Problems |  |  | Genital or Oral Herpes |  |  |
| **GASTROINTESTINAL** |  |  | S.T.D.’s |  |  |
| Constipation | | | Blood in Urine |  |  |
| Diarrhea |  |  | Urinary Tract Infection |  |  |
| Blood in Stool |  |  | Problems Urinating |  |  |
| Nausea/ Vomiting |  |  | Prostate Problems |  |  |
| Liver Problems |  |  | Kidney Problems |  |  |
| **CARDIOVASCULAR** |  |  | **Eyes** |  |  |
| Heart Problems | | | Vision Problems |  |  |
| Deep Vein Thrombosis/ DVT |  |  | **ENT** |  |  |
| Blood Clots in Lungs/ Legs |  |  | Hearing Problems |  |  |
| High Blood Pressure |  |  | Sinus Problems |  |  |
| **RESPIRATORY** |  |  | **PSYCHIATRIC** |  |  |
| Asthma | | | Mood Swings |  |  |
| Sleep Apnea |  |  | Anxiety/ Depression |  |  |

Please list any other conditions/ illnesses not indicated above:

To the best of my knowledge, this information is complete and correct. I understand that it is my responsibility to inform my doctor if there are any changes to my health.

Patient Signature: Date: / /

Physician Signature: Date Reviewed: / /