NEW PATIENT HISTORY

Name:_____ Date of Birth:_____

List of your medications: Conditions for which you are taking this medication:

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

List any other medical conditions you have that are not listed above:

_____

_____

List any medications you are allergic to: Your reaction:

_____ _____

_____ _____

Your preferred pharmacy:_____

List any surgeries that you have had: Year: Surgeon or hospital:

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Have you had a colonoscopy? _____ Date: _____

List any immunizations/vaccines you have had in the past 10 years (include the year):

_____

_____

Occupation:_____

Marital Status:_____

Substance use: Amount: Number of years:

Tobacco:_____ _____

Drugs:_____ _____

Alcohol:_____ _____

Caffeine:_____ _____

FAMILY HISTORY (Please include only blood relatives):

Disease: Relationship to you:

Breast Cancer _____

Colon Cancer _____

Other Cancer _____

Diabetes _____

Heart Disease _____

High Blood Pressure _____

High Cholesterol _____

Stroke _____

Lung Disease (Asthma) _____

Kidney Disease _____

Liver Disease _____

Psychiatry Disease _____

Stomach/Bowel Disease _____

Other:_____ _____

_____ _____

GYNECOLOGIC HISTORY:

Date of last Menstrual Period:_____

Date of last Pap Smear:_____ Any abnormal Pap Smears?_____

Date of last Mammogram:_____

Previous Pregnancies:

Date of Delivery:	Vaginal/C-section:	Complications:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____