NEW PATIENT MEDICAL HISTORY FORM

Patient Name: ______________________________ Date of Birth: __________

Address: ______________________________

Phone Number: ______________________________

Email Address: ______________________________

Emergency Contact Name: ______________________________ Relationship: __________

Emergency Contact Phone: ______________________________

Insurance Information:

Insurance Company: ______________________________

Policy Number: ______________________________

Group Number: ______________________________

Primary Care Physician:

Physician's Name: ______________________________

Phone Number: ______________________________

Medical History:

- ☐ Diabetes
- ☐ Hypertension (High Blood Pressure)
- ☐ Heart Disease
- ☐ Stroke
- ☐ Cancer
- ☐ Asthma or other Lung Diseases
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Thyroid Problems
- ☐ Seizures or Epilepsy
- ☐ Bleeding or Clotting Disorders
- ☐ Mental Health Conditions
- ☐ Allergies to Medications

☐ Other Allergies

☐ Surgeries or Hospitalizations (Please list below)

Medications Currently Taking (Include Dosage and Frequency):

____

____

____

____

____

Allergies (Medications, Food, Environmental):

____

____

____

____

Family Medical History (Check all that apply):

☐ Diabetes

☐ Hypertension

☐ Heart Disease

☐ Stroke

☐ Cancer

☐ Mental Illness

☐ Other (please specify below)

Other Family Medical History:

____

____

____

Social History:

Do you use tobacco products? ■ Yes ■ No

Do you consume alcohol? ■ Yes ■ No

Do you use recreational drugs? ■ Yes ■ No

Occupation: ______________________________

Review of Systems (Please check any symptoms you have experienced recently):

- ☐ Fever or chills
- ☐ Unintentional weight loss or gain
- ☐ Fatigue
- ☐ Headaches
- ☐ Vision changes
- ☐ Hearing loss or ringing
- ☐ Chest pain
- ☐ Shortness of breath
- ☐ Palpitations
- ☐ Abdominal pain
- ☐ Nausea or vomiting
- ☐ Diarrhea or constipation
- ☐ Joint pain or swelling
- ☐ Skin rashes or itching
- ☐ Urinary symptoms
- ☐ Mood changes or depression
- ☐ Sleep disturbances
- ☐ Other (please specify below)

Other symptoms not listed:

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PATIENT SIGNATURE	**PHYSICIAN SIGNATURE**
Signature: ___________________________	Signature: ___________________________

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