Name: _____

Date: _____

NEW PATIENT HISTORY: Adult Version (age 18 years and older)

Allergies:

NONE Foods: _____ Environmental Allergies: _____

Medications: _____

Other: _____

Family History: (please put an "x" in the appropriate box)

Arthritis	Mother	Father	Sibling	Children	Grandparent	Aunt/Uncle
Cancer	Mother	Father	Sibling	Children	Grandparent	Aunt/Uncle
Diabetes	Mother	Father	Sibling	Children	Grandparent	Aunt/Uncle
Heart problems	Mother	Father	Sibling	Children	Grandparent	Aunt/Uncle
High Blood Pressure	Mother	Father	Sibling	Children	Grandparent	Aunt/Uncle
High Cholesterol	Mother	Father	Sibling	Children	Grandparent	Aunt/Uncle
Stroke	Mother	Father	Sibling	Children	Grandparent	Aunt/Uncle
Thyroid Problems	Mother	Father	Sibling	Children	Grandparent	Aunt/Uncle
Obesity	Mother	Father	Sibling	Children	Grandparent	Aunt/Uncle
Liver problems	Mother	Father	Sibling	Children	Grandparent	Aunt/Uncle
Kidney Problems	Mother	Father	Sibling	Children	Grandparent	Aunt/Uncle
Depression/Anxiety	Mother	Father	Sibling	Children	Grandparent	Aunt/Uncle
Blood Disorders	Mother	Father	Sibling	Children	Grandparent	Aunt/Uncle

SOCIAL HISTORY

Marital Status: Single Married Divorced Separated Widowed Cohabitating

Occupation: Retired Disabled

Who lives with you? Home Assisted Living Nursing Home

Education: less than HS level HS College

Do you use tobacco? Never Quit Date: _____ Smoke (_____packs per day) Chew

Do you drink alcohol? Never Quit Date: _____ rarely daily weekly special occasions

Are you sexually active? yes no

Females: Date of Last Menstrual Flow: _____

SURGICAL HISTORY:

Type of Surgery	**Year of Surgery**	**Name of Surgeon**

MEDICAL HISTORY: Have you ever had any of the following? (check ALL THAT APPLY) NONE

allergies	cancer	GERD or frequent heartburn	osteoporosis
anemia	cardiac arrest	high cholesterol	nerve pain
arthritis	celiac disease	hypertension	pulmonary embolism or blood clot in legs
atrial fibrillation	depression	hypothyroidism	seizures
asthma	diabetes	heart disease	shortness of breath
bleeding problems	drug/alcohol abuse	insomnia	sinus conditions
congestive heart failure	enlarged prostate	irritable bowel syndrome	stroke
chest pain	erectile dysfunction	kidney problems	Other:
chronic fatigue syndrome	frequent or prolonged infections	liver problems	
coronary artery disease	fibromyalgia	menopause	
		migraines/headaches	

Immunizations: Out of Date Tetanus Influenza Pneumonia Shingles Hepatitis

Current Medications You Take (please include herbals supplements and any over-the-counter medications):

Signature and Date: