



NEW PATIENT HISTORY FORM

Date _____

PATIENT NAME _____ Date of Birth _____ Sex _____

Primary Care Physician: _____

Chief

Complaint: _____

Medications/Dosage:

PRESENT _____

The PAST year _____

Pharmacy/Phone _____

Are you **allergic** to or intolerant of any drugs? If yes, please list the drug(s) and your reaction. _____

Past operations/dates _____

Other Major Illnesses &

Hospitalizations _____

Do you smoke? _____ Packs/Day _____ Did you smoke? _____ Date Stopped? _____

How often do you have a drink? (Beer, Wine, Liquor)? _____

Have you ever had a problem related to alcohol? _____

Do you take any vitamins/supplements? (Please list): _____

Please circle if there is any family history of: Gout? Alcoholism?

Asthma? Stroke? Arthritis? Cancer? Heart Disease?

Diabetes? Kidney Disease? High Blood Pressure? Mental Illness?

Osteoporosis? Lupus? Scleroderma? Tuberculosis?