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New Patient Medical History

Name _____Age/DOB _____ Today's Date _____
Who do you live with? _____
May I leave messages? _____
Current work/profession: _____
History of exposure to hazardous substances: _____
Known allergies to meds, food, environmental: _____
Tobacco history (smoking/chewing): _____
Alcohol history: _____
Illicit drug history: _____
Exercise: _____
Dietary habits: _____
Caffeinated products: _____
Vitamins/Supplements: _____
Firearms in the home: _____
Seatbelts/protective gear: _____
Living will/power of attorney: _____

PAST MEDICAL HISTORY

HOSPITALIZATIONS/SURGERIES:

_____
_____
_____
_____

CURRENT MEDICATIONS

_____
_____
_____

FAMILY HISTORY

FATHER:_____
MOTHER:_____
SIBLINGS:_____
BIOLOGICAL CHILDREN:_____