New Patient History Form

Patient Name:_____ DOB:_____

Parents Names:_____

Please remember to have the patients immunization record available at time of appointment

Medical History: Please list all current or past illnesses / conditions and indicate for how many years.

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-	-	-
-	-	-

Surgical History: Please list all surgeries and the approximate dates.

-	-
-	-
-	-

Preferred Pharmacy(s): Please list local / mail order pharmacies (only two please).

1	2

Medications: List all Prescription and Non-prescription medications with the dose (mg) and frequency.

Name	Dose (mg)	Frequency	Name	Dose (mg)	Frequency
1			5		
2			6		
3			7		
4			8		

Allergies: Please list all medication / food allergies and the reaction they cause or circle "No know drug allergies" if none apply.

NKDA

-	-
-	-

Social History: Please circle your answer

Does the patient smoke?	YES	NO	Does the patient drink alcohol?	YES	NO
Does the patient use eCigarettes?	YES	NO	Does the patient use recreational drugs?	YES	NO
Does the patient chew tobacco?	YES	NO	Any alternative medications taken (CAM)?	YES	NO

Family History: Please list all current or past illnesses / conditions of immediate family members and indicate for how many years.

Mother:
Father:
Brother(s):
Sister(s):
Grandmother(s) please specify maternal or paternal:
Grandfather(s) please specify maternal or paternal:

Are patients Biological parents still living?

Father- YES NO Mother- YES NO

Adopted patient (circle yes or no if this applies)? YES NO