

NEW PATIENT HEALTH HISTORY

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_\_\_ Today’s Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Primary Care Doctor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Primary Care Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referring Doctor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Referring Doctor Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Preferred Pharmacy Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CHIEF COMPLAINT**

What is the main reason you are seeing the doctor today?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please fill in below or attach list, if available.

**ALLERGIES**: (Please list all medication allergies, including shellfish, etc.) If no allergies, check here: [ ]

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MEDICATIONS**: (Please list all medicines including over-the-counter, supplements and vitamins.) If no medications, check here: [ ]

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SURGERIES:**

|  |  |  |  |
| --- | --- | --- | --- |
| [ ]  Tonsillectomy  | [ ]  Wisdom Tooth | [ ]  Appendectomy  | [ ]  D&C |
| [ ]  Gallbladder Surgery | [ ]  Tubal Ligation | [ ]  C-Section | [ ]  Hysterectomy |
| [ ]  Shoulder Surgery | [ ]  Vasectomy | [ ]  Knee Surgery | [ ]  Laparoscopy |
| [ ]  Hernia Repair | [ ]  Colonoscopy | [ ]  Other:  |  |

If no prior surgeries, check here: [ ]

Weight: \_\_\_\_\_\_\_\_\_\_\_\_\_ Height: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **FAMILY HISTORY:**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | Father | Mother | Brother | Sister | PGF\* | PGM\* | MGF\* | MGM\* |
| Prostate Cancer |  |  |  |  |  |  |  |  |
| Renal Cancer |  |  |  |  |  |  |  |  |
| Bladder Cancer |  |  |  |  |  |  |  |  |
| Testicular Cancer |  |  |  |  |  |  |  |  |
| Heart Attack |  |  |  |  |  |  |  |  |
| Heart Disease |  |  |  |  |  |  |  |  |
| Stroke |  |  |  |  |  |  |  |  |
| High Blood Pressure |  |  |  |  |  |  |  |  |
| High Cholesterol |  |  |  |  |  |  |  |  |
| Diabetes |  |  |  |  |  |  |  |  |
| Kidney Disease |  |  |  |  |  |  |  |  |
| Urinary Stones |  |  |  |  |  |  |  |  |
| Cystic Fibrosis |  |  |  |  |  |  |  |  |
| Tuberculosis |  |  |  |  |  |  |  |  |
| Other Cancer Type:  |  |  |  |  |  |  |  |  |
| Other Family Hx.:  |  |  |  |  |  |  |  |  |

If there is no family history of any of the above, check here: [ ]  If family history is not available, unknown or unobtainable, check here: [ ]  \* PGF – Paternal grandfather (father’s father) PGM – Paternal grandmother (father’s mother) MGF – Maternal grandfather (mother’s father) MGM – Maternal grandmother (mother’s mother)