NEW PATIENT HEALTH HISTORY

Scan into MPI under Chart

Patient Name ___________________________

Preferred Name _________________________

Date of Birth_______________________________

Preferred Pronoun _______________________

Today's Date _______________________________

Language_______________________________

PERSONAL MEDICAL HISTORY

DISEASE/CONDITION	CURRENT	PAST	COMMENTS
Alcohol/Drug Use			
Asthma			
Cancer *(type:_______________________________)*			
Depression/Anxiety/Bipolar/Suicidal			
Diabetes *(type:_____________________________)*			
Emphysema *(COPD)*			
Heart Disease			
High Blood Pressure *(hypertension)*			
High Cholesterol			
Hypothyroidism/Thyroid Disease			
Renal *(kidney)* Disease			
Migraine Headaches			
Stroke			
Other:			
Other:			

MEDICATIONS

MEDICATIONS *(Please list ALL)*	DOSE *(Mg., pill, etc.)*	TIMES PER DAY

If you need more room to list medications, please write them on a blank sheet of paper with the required information

Continued ⟹

Patient Name: ____ DOB: _______________________

NEW PATIENT HEALTH HISTORY

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ALLERGIES ☐ NO ALLERGIES

ALLERGY	ALLERGIC REACTION

SURGERIES AND PROCEDURES

TYPE *(specify left/right)*	DATE	LOCATION/FACILITY

Patient Name: ______________________ DOB: ______________

NEW PATIENT HEALTH HISTORY

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FAMILY MEDICAL HISTORY ☐ NO SIGNIFICANT FAMILY HISTORY IS KNOWN

CHECK ALL THAT APPLY	Alcohol/Drug Abuse	Asthma	Cancer (*type:* ___)	Emphysema (COPD)	Depression/Anxiety	Bipolar/Suicidal	Diabetes	Early Death	Heart Disease	High Cholesterol	High Blood Pressure	Kidney Disease	Stroke	Thyroid Disease	Migraines	Other:___	Other:___	Other:___
Mother																		
Father																		
Brother																		
Sister																		
Child																		
Maternal Grandmother																		
Maternal Grandfather																		
Paternal Grandmother																		
Paternal Grandfather																		
Other:___________________																		

SOCIAL HISTORY

Occupation *(or prior occupation)*:	☐ Retired ☐ Unemployed ☐ LOA ☐ Disabled
Employer:	Years of Education or Highest Degree:
If employed, do you work the night shift? Y N N/A	
Marital Status *(check one)*: ☐ Single ☐ Partner ☐ Married ☐ Divorced ☐ Widowed ☐ Other:_____________________________	
Do you have children? Y N	If yes, how many?

OTHER HEALTH ISSUES

TOBACCO USE	Smoke Cigarettes? Y N *(If you never smoked, please move to Alcohol /Drug Use)*
Current: Packs/day _____ # of Years ______	***Past:*** Quit Date: ___________________ Packs/day _____ # of Years _____
Other Tobacco *(check one)*: ☐ Pipe ☐ Cigar ☐ Snuff ☐ Chew ☐ Vape	

Continued

Patient Name: ____ DOB: ______________________

NEW PATIENT HEALTH HISTORY

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WOMEN'S HEALTH HISTORY

Date of Last Menstrual Cycle:	Age of First Menstruation: ________ Age of Menopause: _______
Total Number of Pregnancies:	Number of Live Births:
Pregnancy Complications:	
Last Pap Smear:	
Last Mammogram:	

MEN'S HEALTH HISTORY

Last Prostate Evaluation:

PREVENTATIVE MEDICINE (EKG, COLONOSCOPY, ETC)

TYPE *(specify left/right)*	**DATE**	**LOCATION/FACILITY**

ANY OTHER INFORMATION NOT LISTED, PLEASE NOTE BELOW

Patient Name: ______________________________ DOB: ______________