

NEW PATIENT HEALTH INFORMATION

Name _____ Date of Birth _____

Please List Your Allergies to Medications:

List Any Other Allergies:

Previous Hospitalizations since Childhood:

(List Date and Reason for Hospitalization, Include any surgery, such as tonsillectomy)

List any chronic medical problem such as high blood pressure, diabetes, elevated cholesterol:

List your current medications, including supplements, vitamins or over the counter products like aspirin, please include the dosage:

Are you married or single:

If you have children list their sex and ages:

Do you smoke? If yes what and how often?

Do you drink alcoholic beverages? If yes how much and how often?

What is your occupation?

Do you use any drugs? If yes, what and how often?

Do any illnesses such as high blood pressure, heart disease, diabetes, colon cancer, breast cancer or prostate cancer run in your family? Please list the disease and family member below:

Please circle any health problem below that you have had in the past:

Eye problems: Glasses for reading or distance, cataracts, eye injuries, macular degeneration, other _____

Endocrine Problems: diabetes, thyroid problems, problems with adrenal glands, other _____

Blood Problems: Anemia, low platelet count, bleeding or coagulation problems other _____

Joint problems: Rheumatoid arthritis, osteoarthritis, lupus, joint injuries, back problems other _____

GI problems: Problems with heartburn, constipation, diarrhea, colitis, other _____

Heart or Lung Problems: Chest pain, asthma, shortness of breath, cough, difficulty exercising _____

Neurological Problems: strokes, seizures, tremors, weakness or numbness, other _____

Kidney Problems: difficulty urinating, leakage, enlarged prostate, kidney stones, frequent infections, other _____