

# Welcome to Our Practice

New patient, please fill out the information below to the best of your ability.

Patient # \_\_\_\_\_ Physician \_\_\_\_\_ Date \_\_\_\_\_

Patient Name \_\_\_\_\_ Chief Complaint \_\_\_\_\_

## Past Medical History

Have you ever had any of the following? (Please Check yes or no: If uncertain, please leave blank.)

Pneumonia Yes  No  Cancer  Yes  No  Stroke  Yes  No

Rheumatic Yes  No  Polio Yes  No  Hepatitis Yes  No

Fever

Heart Disease Yes  No  Glaucoma Yes  No  Ulcer Yes  No

Arthritis Yes  No  Blood Transfusion Disease Yes  No

Venereal Disease Yes  No  High Blood Pressure Yes  No  Thyroid Disease Yes  No

Anemia Yes  No  Asthma Yes  No  Bleeding Tendency Yes  No

Epilepsy Yes  No  Eczema Yes  No

Any Other Diseases

Tuberculosis Yes  No  AIDS or HIV+ Yes  No  Please List \_\_\_\_\_

Diabetes Yes  No

Previous Hospitalizations/Surgeries/Serious Illnesses      When      Hospital/City/State

\_\_\_\_\_

**Medications (Include Nonprescription)**

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**Any Known Drug Allergies:**

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**Patient Social History**

Use of Alcohol:      Never      Rarely      Moderate      Daily

Use of Tobacco:      Never      previously, but quit; \_\_\_\_\_      Current packs/day \_\_\_\_\_

Use of Drugs:      Never      Type/Frequency: \_\_\_\_\_

**Family Medical History:**

	Age	Diseases	If Deceased, cause of death
Father	_____	_____	_____
Mother	_____	_____	_____
Siblings	_____	_____	_____