New Patient History 13 Years and Older

Patient Name: ____________________

DOB: ____________ Date: ____________

MEDICAL HISTORY/MEDICATIONS ☐ See List

MEDICATION NAME	DOSE	DIRECTION	FOR WHAT MEDICAL CONDITION

Do you have any other medical problems not listed above?

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HAVE YOU HAD ANY OF THE FOLLOWING?

HEALTH MAINTENANCE	DATE/YEAR	LOCATION
Tetanus Vaccine		
Pneumonia Vaccine		
Shingles Vaccine		
Influenza Vaccine		

HEALTH MAINTENANCE	DATE/YEAR	LOCATION	RESULTS
Colonoscopy			
Mammogram			
Pap Smear			
Bone Density Test			

SOCIAL HISTORY

Do you currently use tobacco?	☐ Never user	☐ Former user	☐ Current everyday user	☐Current someday user
What kind of tobacco?	☐ Cigarettes	☐Cigars	☐Chewing tobacco	☐Other
At what age did you start smoking?		At what age did you quit smoking?	Do you consume alcohol? Yes ☐ No ☐	
How much tobacco do you use per day?	________packs per day	_____cans of smokeless tobacco per day	How much per day_______week_______month________	

SURGERIES/OPERATIONS

DATE	SURGERY/OPERATION

DRUG ALLERGIES ☐ No Drug Allergies

MEDICATION	REACTION

FAMILY HISTORY

Please list any family members in your ***IMMEDIATE*** family with any of the following medical issues		LIVING? YES OR NO (If deceased, what age)
Hypertension (high blood pressure)		
Hypercholesterolemia (high cholesterol)		
Diabetes		
Heart Disease/Heart Attack		
Cancer and Type		
Other:		