New Patient Health History

Patient Name: _____ Date of Birth: _____
Today's Date: _____

List **all** prescription medicines you are taking:

_____

_____

_____

_____

_____

_____

List **all** hospitalizations/surgeries and dates:

_____

_____

List **all** over the counter medicines, supplements/vitamins you are taking:

_____

_____

Medication allergies/reactions:

_____

Immunizations – List year received:

_____

_____

Colonoscopy – List year (if any): _____

Mammogram – List year (if any): _____

Family Tree

Family	Circle below	
Mother	Alive	Deceased
Father	Alive	Deceased
Sister	Alive	Deceased
Brother	Alive	Deceased
Maternal Aunt	Alive	Deceased
Maternal Uncle	Alive	Deceased
Paternal Aunt	Alive	Deceased
Paternal Uncle	Alive	Deceased
Mother's Mother	Alive	Deceased
Mother's Father	Alive	Deceased
Father's Mother	Alive	Deceased
Father's Father	Alive	Deceased

List which family members (related to you) have or had the following illnesses.

Diabetes	
Heart Disease	
Stroke / blood clots	
Cancer	
Depression	
Alcoholism	
Drug abuse	
High blood pressure	
Liver disease / Hepatitis	
Thyroid disease	
Urinary / Kidney disease	
Tuberculosis	
Osteoporosis	
Skin disorders	
Epilepsy / seizures	
Other _____	

Do you have an End-of-Life Decision Making document, Living Will or Power of Attorney (Advanced Directive)?
circle one **Yes** **No**