NEW PATIENT/PAST MEDICAL HISTORY

Name: _____

Ongoing medical problems (high blood pressure, high cholesterol, heartburn, etc.)

Current Medications	**Dose**	**Once/Twice/Three times per day**

Drug Allergies	**What was the reaction?**

Prior Surgeries	**Date**

Past Medical History/Major Events (stroke, cancer, etc.)	**Date**

Preferred Pharmacy: _____

PLEASE SEE OTHER SIDE

NEW PATIENT/PAST MEDICAL HISTORY

Social History:

☐ Married

☐ Common-Law Marriage

☐ Single

☐ Divorced

____# Adult Children ____# Children Living at Home

Current Occupation: _____

Retired/Former Occupation: _____

Alcohol Use:

None/Never ____ Rare/Social Drinking (less than monthly) ____

Drinks Per Week # ____ Drinks Per Day # ____

Tobacco Use:

None/Never ____ Past Tobacco User ____

Current Tobacco User:

Cigarettes Per Day # ____/Packs Per Day # ____ Years You Have Smoked # ____

Current/Past Illegal Drug Use: _____

Family History of Medical Problems:

Father	
Mother	
Siblings	
Maternal: Grandmother	
Grandfather	
Paternal: Grandmother	
Grandfather	
Other Family Members	