New Patient Medical History Form

Name:_____ **Date of Birth:**_____ **Appointment Date:**_____

Medical History: *Please check if you have experienced the following.*

- ☐ Alzheimer's Disease
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Back Pain
- ☐ Cancer _____
- ☐ Chronic Obstructive Pulmonary disease (COPD)
- ☐ Congestive heart failure
- ☐ Coronary artery disease
- ☐ Depression
- ☐ Diabetes Type 1
- ☐ Diabetes Type 2
- ☐ Erection Difficulties
- ☐ Emphysema/Lung Disease
- ☐ Gastro esophageal reflux disease (GERD)
- ☐ Glaucoma
- ☐ Gout
- ☐ Heart Attack
- ☐ Heart Murmur
- ☐ Heart Stents
- ☐ Hernia
- ☐ High Blood Pressure/Hypertension
- ☐ High Cholesterol
- ☐ History of Blood Clot
- ☐ Hyperlipidemia
- ☐ Hypogonadism
- ☐ Inability to urinate
- ☐ Kidney Stones
- ☐ Lupus
- ☐ Mitral Valve Prolapse
- ☐ Morbid Obesity
- ☐ Multiple Sclerosis
- ☐ Neck Pain
- ☐ Osteoporosis
- ☐ Pancreatitis, Chronic
- ☐ Parkinson's Disease
- ☐ Thyroid Problems
- ☐ Sleep Apnea
- ☐ Stroke
- ☐ Urinary Infections (#/mths_____)
- ☐ Other_____

Past Surgeries: *Please check if appropriate and list approximate year.*

- ☐ Adenoidectomy, Yr ____
- ☐ Appendectomy, Yr ____
- ☐ Back Surgery, Yr ____
- ☐ Carpal Tunnel Release, Yr __
- ☐ Cesarean Section (C-Section), Yr ____
- ☐ Cholecystectomy (Gallbladder), Yr___
- ☐ Colon Surgery, Yr____
- ☐ Cystoscopy, Yr ____
- ☐ Heart Surgery Yr _____
- ☐ Hernia Surgery/Removal Yr_____
- ☐ Hip Replacement,left,Yr ____
- ☐ Hip Replacement,right, Yr ____
- ☐ Hysterectomy, Yr ____
- ☐ Kidney Removal, Yr ____
- ☐ Knee Arthroscopy, left, Yr ____
- ☐ Knee Arthroscopy, right Yr ____
- ☐ Knee Replacement, left Yr ____
- ☐ Knee Replacement, right, Yr ____
- ☐ Pacemaker, Cardiac, Yr ____
- ☐ Stone Removal, Yr ____
- ☐ Tonsillectomy Yr ____
- ☐ Tubal Ligation, Yr ____
- ☐ Urethral Stents, Yr ____
- ☐ Urolift, Yr_____
- ☐ Wisdom Teeth Extraction, Yr ____
- ☐ Vasectomy, Yr _____
- ☐ Other _____, Yr _____

Family History: *Place check appropriate box below.*

	Diabetes	Hypertension	Heart Disease	Mental Illness	Cancer (type)
Father					
Mother					
Sister(s)					
Brother(s)					
Son					
Daughter					
Paternal Grandfather					
Paternal Grandmother					
Maternal Grandfather					
Maternal Grandmother					

Social History:

Marital Status: married, single, divorced, widowed How many children do you have? _____

Occupation (current or former): _____

Pharmacy Name, Location and Phone	
Allergies and reactions	
Current medications and what condition you take the medication for.	
Over-the counter medications taken regularly (including vitamins, herbs, and aspirin).	

Please use the back of the paper if necessary.