

**NEW PATIENT MEDICAL INFORMATION**

**DATE:** \_\_\_\_\_

**NAME:** \_\_\_\_\_ **BIRTHDATE:** \_\_\_\_\_ **SEX:** M F

**MEDICATION ALLERGIES:** \_\_\_\_\_

**MEDICATIONS** (please list name, dose and number of times per day taken):

Please also list Vitamins, Herbs and Supplements (use back of page if needed)

- 1) \_\_\_\_\_
- 2) \_\_\_\_\_
- 3) \_\_\_\_\_
- 4) \_\_\_\_\_
- 5) \_\_\_\_\_
- 6) \_\_\_\_\_
- 7) \_\_\_\_\_
- 8) \_\_\_\_\_

**SURGERIES:** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please indicate any **MEDICAL CONDITIONS** you or your **immediate** family have/had:

Hypertension	me	other: _____	Cancer (type: _____)	other: _____
Diabetes	me	other: _____	Asthma	me other: _____
Heart disease	me	other: _____	Depression	me other: _____
High Cholesterol	me	other: _____	Mental illness	me other: _____
Thyroid	me	other: _____	Sudden Death	me other: _____
Bleeding or Clots	me	other: _____	Osteoporosis	me other: _____
Stroke	me	other: _____	Other	_____

Marital Status:    Single        Divorced    Separated    Widowed    Married

Number of Children: \_\_\_\_\_

Occupation: \_\_\_\_\_

Smoke: In the past Y N      Currently Y N    Packs per Day \_\_\_\_\_ # of years \_\_\_\_\_

Drink: In the past Y N Currently Y N    Average # of drinks per week \_\_\_\_\_

Drugs: In the past Y N Currently Y N    What Drug(s) \_\_\_\_\_

Chew: In the past Y N Currently Y N

Caffeine: Amount per day \_\_\_\_\_

Do you exercise regularly Y N