New Patient Medical History

Patient Name: _____ **Do you have an Advance Directive?** YES NO

Reason for visit: _____

Primary Care Physician: _____ Phone: _____

Patient's occupation: _____ Employer: _____

Is your visit due to an accident or injury? (Please circle) YES NO **If so, did it occur at work?** YES NO

Are you breast feeding and/or pregnant? YES NO

Please list all prescription and over the counter medications that you are currently taking, with dose:

_____

_____

Do you have or are you being treated for any of the following? (Please circle)

Anemia Asthma Arthritis Diabetes Drug Reactions HIV/AIDS Heart disease High Blood Pressure Stomach/Intestinal Disorders

Are you allergic to: (Please circle) Sulfa Drugs Hydrocodone Aspirin Penicillin Local anesthetic Latex Adhesive tape Other: _____

Please list significant illnesses, injuries, or surgeries within the past 5 years:

_____

Family history: Mother: ____ Alive ____ Deceased Health History: _____

Father: ____ Alive ____ Deceased Health History: _____

How many? Brother(s): ____ Sister (s) _____ Health History: _____

Son(s): _____ Daughter(s):____ Health History: _____

Smoking Status: (Please circle one) Current Smoker Former Smoker Non-smoker

Chewing Tobacco: (Please circle) Never Current user Former smoker Other

Do you drink alcohol? YES NO **If yes, what type?** Wine Beer Liquor **How often?** Socially Daily Rarely

Do you exercise regularly? YES NO **If yes, what type?** Walking Running Biking Swimming Hiking Yoga Pilates Zumba Other

Use of recreational drugs? YES NO **If yes, what type**? _____ **How often?** _____

Shoe size: _____ **Height**: _____ **Weight**: _____

Alcohol Screening

Did you have a drink containing alcohol in the past year?

- Never
- Monthly or less
- Two or four times a month
- Two or three times per week
- Four or more times a week

If 'Yes': How many drinks did you have on a typical day when you were drinking in the past year?

- 1 or 2
- 3 or 4
- 5 or 6
- 7 to 9
- 10 or more

If 'Yes': How often did you have six or more drinks on one occasion in the past year?

- Never
- Less than monthly
- Monthly
- Weekly
- Daily or almost daily