



NEW PATIENT HEALTH HISTORY

Name _____ Male / Female Today's Date: _____

Date of Birth: ____ / ____ / ____ Do You Smoke? YES NO How much? _____

Previous Surgeries: _____

Medical Problems: _____

Allergic to Medications? Y ____ N ____ Which meds? _____

Medications: _____

Primary Care Doctor _____ Last exam: _____ Last tetanus: _____

OB/Gyn: _____ Last exam? _____

Family Disease:

Diabetes + -- _____ Cancer + -- _____ Heart Disease + -- _____

Other _____

Married / Single / Divorced Number of Children _____ Their Ages _____

Other Social History: _____

