New Patient History and Physical

Date: __________

Patient's Name: ______________________________ Date of Birth: ___________________________

Reason for visit: ____

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HT: ______ WT: ______ BP: ________ HR: _____ O2: _____ RR: _____ Temp: ______

PAST MEDICAL HISTORY: (Please list any medical problems you have been diagnosed with in the past.)

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CURRENT MEDICATIONS: (Please list all medications that you take daily.)

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ALLERGIES: (Medications/Food and Reaction)

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SURGICAL HISTORY: (Please list all surgeries that you have had in the past.)

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HOSPITALIZATIONS: (Please list any overnight hospital stays and reason.)

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FAMILY HISTORY: (Please list any **chronic illnesses** which have occurred in your **blood relatives**)

Mother: ____

Father: ____

Grandparents: ____

Brothers: ____

Sisters: ____

SOCIAL HISTORY:

Do you use any form of tobacco? ____

If yes, what kind? How much? ____

Do you drink any type of alcohol? ____

If yes, how much? How often? ____

Do you use any type of illegal drugs? ____

OTHER: (Please list any other information you would like for us to know.)

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