New Patient Medical History

Last Name:	First Name:	MI:	Date:

MEDICAL HISTORY

PLEASE LIST ALL YOUR OTHER MEDICAL PROBLEMS, ILLNESSES, HOSPITALIZATIONS

SURGICAL HISTORY

PLEASE LIST ALL YOUR OPERATIONS

Social History

Smoking History	Current: _____ppd x _____ years ☐ Ex-smoker: ☐ NEVER	ALCOHOL USE ☐ YES ☐ NO ☐ Socially ☐ Light ☐ Moderate ☐ Heavy
Illicit substance use in the last year	Yes No	
Last Flu Shot:	Last: Mammogram:	Last PAP Smear:

Family History

PLEASE CIRCLE ANY CONDITION(S) THAT HAS AFFECTED YOUR FOLLOWING FAMILY MEMBER:

Father	Mother	Siblings
Heart attack	Heart attack	Heart attack
Bypass surgery, angioplasty, or stents	Bypass surgery, angioplasty, or stents	Bypass surgery, angioplasty, or stents
Diabetes	Diabetes	Diabetes
High blood pressure	High blood pressure	High blood pressure
High cholesterol	High cholesterol	High cholesterol
sudden cardiac death	sudden cardiac death	sudden cardiac death
Asthma, COPD,	Asthma, COPD,	Asthma, COPD,