

NEW PATIENT MEDICAL HISTORY

Patient Name _____ **Date** _____

1. Please list **all** medications you are currently taking (including aspirin and vitamins). You may use the back of this form for additional medications if necessary.

Medication	Strength	Qty. Daily	Medication	Strength	Qty. Daily
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

2. Are you allergic to any medications? If so, please list: _____

3. Medical History – major illnesses, hospitalizations, etc. (please include dates) _____

4. Surgical History (please include dates) _____

5. Do you smoke? _____ Quantity? _____

6. Do you drink alcohol? _____ Quantity? _____

7. Family History (please list any major illness or cause of death)

Mother _____

Father _____

Siblings _____

8. Why are you seeing the doctor today? _____

9. Please list all medications that you have previously tried for this condition. _____
