NEW PATIENT MEDICAL INFORMATION

DATE: ______________

NAME: _____________________________ **BIRTHDATE:** __________ **SEX:** M F

MEDICATION ALLERGIES:____

MEDICATIONS (please list name, dose and number of times per day taken):
Please also list Vitamins, Herbs and Supplements (use back of page if needed)

1)____
2)____
3)____
4)____
5)____
6)____
7)____
8)____

SURGERIES: ____
____
____
____

Please indicate any MEDICAL CONDITIONS you or your **immediate** family have/had:

Hypertension	me	other:_________	Cancer (type:__________)other:_________		
Diabetes	me	other:_________	Asthma	me	other:_________
Heart disease	me	other:_________	Depression	me	other:_________
High Cholesterol	me	other:_________	Mental illness	me	other:_________
Thyroid	me	other:_________	Sudden Death	me	other:_________
Bleeding or Clots	me	other:_________	Osteoporosis	me	other:_________
Stroke	me	other:_________	Other_______________________________		

Marital Status: Single Divorced Separated Widowed Married
Number of Children:_____
Occupation:______________________________________
Smoke: In the past Y N Currently Y N Packs per Day____ # of years_____
Drink: In the past Y N Currently Y N Average # of drinks per week________
Drugs: In the past Y N Currently Y N What Drug(s)____________________________
Chew: In the past Y N Currently Y N
Caffeine: Amount per day________________
Do you exercise regularly Y N