Patient Name: _____

Primary doctor: _____

Referring doctor: _____

New Patient Health History Form

Your answers on this form will help your health care provider better understand your medical concerns and conditions. Please take time to complete this questionnaire before your appointment. **Thank you!**

Main reason for today's visit:

_____

PATIENT HEALTH HISTORY: Please check any current and/or past problems.

___ Alcoholism
___ Anemia
___ Arthritis / Rheumatoid Arthritis_____
___ Asthma
___ Autism
___ Autoimmune Disorder/ Lupus/ Epstein Barr/ CVID
___ Cancer, if yes please specify which type: _____
___ Cholesterol
___ COPD
___ Crohn's Disease
___ Diabetes if yes please specify which type: _____
___ Fibromyalgia/ Multiple Sclerosis
___ Hypertension
___ Hypothyroidism
___ Infections Disease (HIV/TB)
___ Migraines
___ Neurological Disorder / Seizures
___ Osteoporosis
___ Psychological/Mental Disorder/ Depression / Anxiety Other: _____
___ Urticaria/ Dermatitis/ Eczema
___ Valley Fever

♦ Are you currently pregnant or expect to become pregnant? Yes _____ No _____

♦What medications are you currently taking? (Include over-the-counter products, vitamins, and herbal remedies)

_____ _____
_____ _____
_____ _____

♦Have you been hospitalized? Please list approximate dates and reasons:

_____ _____
_____ _____

♦Have you had surgery? Please list approximate dates and reasons:

_____ _____
_____ _____

♦Do you have any medication allergies? Yes _____ No _____

If **YES** please list:

_____

IMMUNIZATIONS:

♦Flu shot last received: _____ ♦ Covid vaccine? Yes ___ No ___ Brand: _____ Quantity: ____

WORKPLACE ENVIRONMENT:

Do you work indoors/outdoors? _____ Occupation: _____

(OVER)

FAMILY HISTORY: (Please indicate family members with any of the following conditions):

	Mother	Father	Brother	Sister	Other:_____ (specify relationship)
Alcoholism	□	□	□	□	□
Allergies	□	□	□	□	□
Anemia	□	□	□	□	□
Anxiety	□	□	□	□	□
Arthritis	□	□	□	□	□
Asthma	□	□	□	□	□
Autism	□	□	□	□	□
Celiac Disease	□	□	□	□	□
Cholesterol	□	□	□	□	□
Congenital Heart Disease	□	□	□	□	□
COPD	□	□	□	□	□
Diabetes	□	□	□	□	□
Depression	□	□	□	□	□
Eczema (Atopic dermatitis)	□	□	□	□	□
Emphysema	□	□	□	□	□
Food Allergies	□	□	□	□	□
Hearing Loss	□	□	□	□	□
Hypertension	□	□	□	□	□
Hemophilia	□	□	□	□	□
Immunologic Disorder	□	□	□	□	□
Lupus	□	□	□	□	□
Migraines	□	□	□	□	□
Renal Disease	□	□	□	□	□
Seizures	□	□	□	□	□
Thyroid Disorder	□	□	□	□	□
Urticaria (Hives)	□	□	□	□	□
Uterine Cancer	□	□	□	□	□
Valley Fever	□	□	□	□	□

ENVIRONMENT/SOCIAL HISTORY:

Do you have pets at home? Yes ___ No ___ What type of flooring is in the home? Circle all that apply

Carpet Tile Laminate Wood Other:_____

If **YES**, please specify type and if they are indoors/outdoors or both:

_____

SOCIAL BEHAVIOR

- Smoking Status: □ Current □ Former □ Never
- Passive Smoke: □ Yes □No
- HIV Risk: □ Yes □ No
- Drug Use: □ Yes □ No
- Alcohol Use: □ Yes □ No

♦Have you had previous allergy testing done thru lab work or skin test? If so please list when and where testing was performed (ex; Quest Diagnostics, PAL, Foundation Lab, LabCorp or doctor's office):

_____

FOR WOMEN ONLY:

When was your last Pap smear? (Please list approximate date done- if you've had a Hysterectomy list date of surgery)

_____

When was your last Mammogram? (Please list approximate date)

_____

When was your last Colonoscopy? (Please list approximate date)

_____

FOR MEN ONLY: When was your last Colonoscopy? (Please list approximate date) _____