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.

___ 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
___ 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	☐	☐	☐	☐	☐
Breast Cancer	☐	☐	☐	☐	☐
Cervical Cancer	☐	☐	☐	☐	☐
Coronary Heart Disease (CAD)	☐	☐	☐	☐	☐
Colon Cancer	☐	☐	☐	☐	☐
Colon Polyps	☐	☐	☐	☐	☐
Congenital Heart Disease	☐	☐	☐	☐	☐
Deafness	☐	☐	☐	☐	☐
Depression	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐
Huntington’s disease	☐	☐	☐	☐	☐
Hypertension	☐	☐	☐	☐	☐
Kidney/Renal Disease	☐	☐	☐	☐	☐
Lung Cancer	☐	☐	☐	☐	☐
Lung/Respiratory Disease	☐	☐	☐	☐	☐
Melanoma (MI)	☐	☐	☐	☐	☐
Migraines	☐	☐	☐	☐	☐
Osteoporosis	☐	☐	☐	☐	☐
Ovarian Cancer	☐	☐	☐	☐	☐
Pancreatic Cancer	☐	☐	☐	☐	☐
Prostate Cancer	☐	☐	☐	☐	☐
Seizures	☐	☐	☐	☐	☐
Skin Cancer (Malignant)	☐	☐	☐	☐	☐
Stroke/CVA	☐	☐	☐	☐	☐
Suicide	☐	☐	☐	☐	☐
Thyroid Disease	☐	☐	☐	☐	☐

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
- Vaping e-cigarette ☐ Yes ☐No
- 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) ______________________