Name ______________________________________ Date of Exam______________________

Referred by ___________________________________ Date of Birth______________________

## Reason for your Visit:

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

## Other Medical Concerns:

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

## Past Medical History

Medications - All medications you are currently taking, including over the counter

| Name | Dosage (Milligrams) | Times per day |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

Operations

| Type of Operation | Date of Operation |
|---|---|
| | |
| | |
| | |
| | |
| | |

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# New Patient Evaluation - Page 2

## Past Medical History

Previous Illnesses - i.e, pneumonia, injuries, hospitalization, etc.

Illness                                   Date of Illness

___

___

___

___

Medication Allergies

Medication                                   Type of Reaction

___

___

___

___

## Family History

| Relationship | Status | | Age | Illnesses or cause of death |
|---|---|---|---|---|
| Father | ☐ Living | ☐ Deceased | ___ | ___ |
| Mother | ☐ Living | ☐ Deceased | ___ | ___ |
| Sisters | ☐ Living | ☐ Deceased | ___ | ___ |
| | ☐ Living | ☐ Deceased | ___ | ___ |
| Brothers | ☐ Living | ☐ Deceased | ___ | ___ |
| | ☐ Living | ☐ Deceased | ___ | ___ |

## Social History

Marital Status: ☐ Single ☐ Married ☐ Divorced  Children: ☐ Yes ☐ No  How many? ___

Smoke: ☐ Yes ☐ No If YES, how many per day? ___

Alcohol Consumption: ☐ Yes ☐ No If YES, how many per day? ___ Per week? ___

Occupation: ___

Hobbies/Interest: ___

___

___

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