New Patient Medical History

Patient: _______________________________ **Date of Birth:** ____________________

PCP:___________________________ **Pharmacy Name & Ph#**__________________________

Medical History: Circle if you have any of the following:

Asthma Angina/Chest pain Anemia Arthritis Cancer Bronchitis

COPD Liver disease Clotting disorder Diabetes Gallstones

Heart attack Heart Murmur Hepatitis High blood pressure High Cholesterol

HIV/Aids Kidney disease Rheumatic Fever Stroke Thyroid Disease

Blood clots Leg Swelling Others:____

Do you have a Living will? Yes No

Do you have a Power of Attorney? Yes No If yes, who?____________________________

Family History:

Diabetes Heart Attack High Blood pressure Kidney disease Stroke

Operations and/or Hospitalizations:

Reason	Date	Reason	Date

Allergies to Medication:

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____

Habits:

Sleep? Snore Daytime drowsiness Difficulty falling asleep

Smoke? Yes or No IF so, how many a day and how long?____________________________________

Alcohol? Yes or No If so, type, frequency and amount?____________________________________

Medications? Yes or No If yes, what meds?__PLEASE LIST ON NEXT PAGE____________________

Medication	Dose	Frequency	Reason