NEW PATIENT MEDICAL HISTORY

Story Medical CLINICS

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Name: _____ MR No: _____ DOB: _____

PERSONAL HISTORY OF ILLNESS (Check any illness, past or present)

☐ Head injury	☐ Asthma	☐ Lung disease	☐ Anemia	☐ Skin trouble
☐ Migraine headache	☐ Hay fever	☐ Pneumonia	☐ Diabetes	☐ Gout/Arthritis
☐ Epilepsy (seizure)	☐ Thyroid disease	☐ Stomach ulcers	☐ Alcohol abuse	☐ High cholesterol
☐ Mental illness	☐ Heart disease	☐ Liver disease	☐ Venereal disease	☐ Rheumatic fever
☐ Eye disease	☐ High blood pressure	☐ Kidney disease	☐ Broken bones	☐ Recurrent ear infection

☐ Other: _____

SURGERIES AND HOSPITALIZATIONS

Year	Surgery or reason for hospitalization	Year	Surgery or reason for hospitalization
1. _____	_____	5. _____	_____
2. _____	_____	6. _____	_____
3. _____	_____	7. _____	_____
4. _____	_____	8. _____	_____

ALLERGIES

Are you allergic to any medications? ☐ Yes ☐ No If yes, what? _____

Any other allergies (latex, rubber, etc.)? _____

FAMILY HISTORY

Is there any history of the following diseases in your family? If yes, indicate which relative.

DISEASE	WHICH RELATIVE	DISEASE	WHICH RELATIVE
Cancer	_____	Heart disease	_____
Stroke	_____	High blood pressure	_____
Diabetes	_____	Tobacco/Alcohol abuse	_____
Asthma/Lung disease	_____	Reaction to anesthesia	_____
Depression	_____	Other: _____	_____

SOCIAL HISTORY

☐ Married ☐ Widowed ☐ Single ☐ Divorced Occupation: _____

Are you in a relationship where you feel unsafe: ☐ Yes ☐ No

Children: ☐ No ☐ Yes-How many: _____ Caffeine use: ☐ No ☐ Yes-How much: _____ (coffee, tea, cola)

Exercise: ☐ No ☐ Yes-How often: _____

Drug use: ☐ No ☐ Yes-How often: _____ Alcohol use: ☐ No ☐ Yes-How much: _____

(Marijuana, LSD, Speed, Heroin, Methamphetamine, etc.) (including beer and wine)

Tobacco use: ☐ No If quit, how long did you smoke? _____ ☐ N/A

☐ Yes How much: _____ Year began: _____

Do you have a living will/advanced directives? ☐ Yes ☐ No Do we have a copy? ☐ Yes ☐ No

Clinic use only: Updated/Review Initial/Date: _____ Initial/Date: _____ Initial/Date: _____