

**NEW PATIENT MEDICAL HISTORY**



Nevada *ph 515-382-5413*  
*f 515-382-7108*

Maxwell *ph 515-387-8815*  
*f 515-387-8817*

Slater *ph 515-685-3960*  
*f 515-685-3961*

Zearing *ph 641-487-7779*  
*f 641-487-7749*

Name: \_\_\_\_\_ MR No: \_\_\_\_\_ DOB: \_\_\_\_\_

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

- |   |  |   |   |  |
|---|--|---|---|--|
| <input type="checkbox"/> Head injury        | <input type="checkbox"/> Asthma              | <input type="checkbox"/> Lung disease   | <input type="checkbox"/> Anemia           | <input type="checkbox"/> Skin trouble            |
| <input type="checkbox"/> Migraine headache  | <input type="checkbox"/> Hay fever           | <input type="checkbox"/> Pneumonia      | <input type="checkbox"/> Diabetes         | <input type="checkbox"/> Gout/Arthritis          |
| <input type="checkbox"/> Epilepsy (seizure) | <input type="checkbox"/> Thyroid disease     | <input type="checkbox"/> Stomach ulcers | <input type="checkbox"/> Alcohol abuse    | <input type="checkbox"/> High cholesterol        |
| <input type="checkbox"/> Mental illness     | <input type="checkbox"/> Heart disease       | <input type="checkbox"/> Liver disease  | <input type="checkbox"/> Venereal disease | <input type="checkbox"/> Rheumatic fever         |
| <input type="checkbox"/> Eye disease        | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Broken bones     | <input type="checkbox"/> 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.

<u>DISEASE</u>	<u>WHICH RELATIVE</u>	<u>DISEASE</u>	<u>WHICH RELATIVE</u>
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: \_\_\_\_\_  
Exercise:  No  Yes-How often: \_\_\_\_\_ (coffee, tea, cola)  
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: \_\_\_\_\_