

NEW PATIENT MEDICAL HISTORY



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

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

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: _____