New patient history form

Patient name ____**DOB**______________________

Allergies____

Current Medications

Name	Dose	Times/day taken

Social History

Married/single/widowed/divorced

Number of pregnancies__________________________live births________________________________

Occupation____

Highest level of education____

Drug use Y/N, if yes____

Alcohol consumption (avg # drinks/week)________________________________

Medical History

Please check off all applicable personal medical diagnoses received by a doctor

High blood pressure Heart disease Diabetes

Thyroid disease Kidney problems COPD/asthma

Reflux Stomach ulcers Liver problems

Autoimmune Disease (Lupus/RA/Sjogrens/Vasculitis)____

Frequent infections (please specify)____

Other____

Surgical History (please list surgeries and dates)

Surgery	Date

Family History (please list age and health conditions)

Mother - Alive/Deceased ____

Father - Alive/Deceased____

Siblings

1. ____
2. ____
3. ____
4. ____
5. ____
6. ____

Family with an autoimmune condition (lupus, rheumatoid arthritis) – yes/no

If yes, please list ____