



**NEW PATIENT**  
**HEALTH HISTORY**

<b>Last Name</b>	<b>First Name</b>	<b>Date of Birth</b>	<b>Today's Date</b>
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**NOTE: PLEASE LET THE MEDICAL ASSISTANT KNOW IF YOU NEED REFILLS OF PRESCRIPTIONS TODAY**

Please check any condition you have had or presently have now:											
	YES	NO		YES	NO		YES	NO		YES	NO
Abdominal Pain	<input type="checkbox"/>	<input type="checkbox"/>	Deafness	<input type="checkbox"/>	<input type="checkbox"/>	Indigestion	<input type="checkbox"/>	<input type="checkbox"/>			
Alcohol Use	<input type="checkbox"/>	<input type="checkbox"/>	Depression	<input type="checkbox"/>	<input type="checkbox"/>	Insomnia	<input type="checkbox"/>	<input type="checkbox"/>			
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>			
Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	Liver Cirrhosis	<input type="checkbox"/>	<input type="checkbox"/>			
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty Swallowing	<input type="checkbox"/>	<input type="checkbox"/>	Nausea / Vomiting	<input type="checkbox"/>	<input type="checkbox"/>			
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty/Frequent Urinating	<input type="checkbox"/>	<input type="checkbox"/>	Numbness / Tingling	<input type="checkbox"/>	<input type="checkbox"/>			
Blood Disorders	<input type="checkbox"/>	<input type="checkbox"/>	Drug Abuse	<input type="checkbox"/>	<input type="checkbox"/>	Piercings	<input type="checkbox"/>	<input type="checkbox"/>			
Blood in Stool	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy / Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Respiratory Problems	<input type="checkbox"/>	<input type="checkbox"/>			
Blood in Urine	<input type="checkbox"/>	<input type="checkbox"/>	Gallbladder Disease	<input type="checkbox"/>	<input type="checkbox"/>	Skin Problems	<input type="checkbox"/>	<input type="checkbox"/>			
Blood Transfusions	<input type="checkbox"/>	<input type="checkbox"/>	Gout	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>			
Breast Masses / Discharge	<input type="checkbox"/>	<input type="checkbox"/>	Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>	Swollen Ankles	<input type="checkbox"/>	<input type="checkbox"/>			
Caffeine User	<input type="checkbox"/>	<input type="checkbox"/>	Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Tattoos	<input type="checkbox"/>	<input type="checkbox"/>			
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	TB	<input type="checkbox"/>	<input type="checkbox"/>			
Change in Appetite	<input type="checkbox"/>	<input type="checkbox"/>	Hemorrhoids	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>			
Change in Bowel Habits	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis A	<input type="checkbox"/>	<input type="checkbox"/>	Tobacco Use	<input type="checkbox"/>	<input type="checkbox"/>			
Chest Pain / Tightness	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis B	<input type="checkbox"/>	<input type="checkbox"/>	Urinary Incontinence	<input type="checkbox"/>	<input type="checkbox"/>			
Cholesterol High	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis C	<input type="checkbox"/>	<input type="checkbox"/>	Venereal Disease	<input type="checkbox"/>	<input type="checkbox"/>			
Colitis	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Weight Gain / Loss	<input type="checkbox"/>	<input type="checkbox"/>			
Constipation	<input type="checkbox"/>	<input type="checkbox"/>	HIV	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>			
Coughing Blood	<input type="checkbox"/>	<input type="checkbox"/>	Hypertension	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>			

Do you see any other physicians?	Reason	Prior Surgeries	Date

Prior Exams and Tests	Date	Prior Exams and Tests	Date
Last Physical Exam		Last Dexascan	
Last Stress Test		Last Eye Exam	
Last Colonoscopy		Last Zostavax Vaccine	
Last OB/GYN Exam		Last Flu Shot	
Last PAP		Last Tetanus Shot	
Last Mammogram		Last Pneumovax Shot	
Last Blood Work and Where			

Patient Signature: \_\_\_\_\_

