New Patient History Form

Patient Name: _____ Date of Birth: _____

Medication List

Medication Name (Include over the counter medication)	Strength / Dose (mg)	Number of pills per dose	Number of times Per day
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____
4. _____	_____	_____	_____
5. _____	_____	_____	_____
6. _____	_____	_____	_____
7. _____	_____	_____	_____
8. _____	_____	_____	_____
9. _____	_____	_____	_____
10. _____	_____	_____	_____

Past Medical History

Diabetes	____ Yes	___ No		Mental Illness	____ Yes	___ No
High Blood Pressure	____ Yes	___ No		Dementia (Alzheimer's etc.)	____ Yes	___ No
Stroke	____ Yes	___ No		Seizures	____ Yes	___ No
Heart Disease / Heart Attack	____ Yes	___ No		Cancer	____ Yes	___ No
High Cholesterol	____ Yes	___ No		• Cancer Type		
Thyroid Disease	____ Yes	___ No		Cardiomyopathy	____ Yes	___ No
(PVD) Vascular Disease	____ Yes	___ No		CHF Congestive Heart Failure	____ Yes	___ No
Bleeding Disorder	____ Yes	___ No		Atrial Fibrillation	____ Yes	___ No
Emphysema / COPD	____ Yes	___ No		Other:	____ Yes	___ No
Liver Disease	____ Yes	___ No				
Rheumatic Fever	____ Yes	___ No				
Asthma	____ Yes	___ No				
Ulcers	____ Yes	___ No				

Drug/Non-Drug Allergy	Allergic Reaction

Patient Name: _____ Date of Birth: _____

Cardiac and Vascular History/Procedures

Previous Procedures	**Year**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

	Living	**Age**	**Deceased**	**Age at Death**	**Medical History (Ex. Diabetes, Stroke, Heart Attack)**
Father	☐		☐		
Mother	☐		☐		
Brother(s)	☐		☐		
Sister(s)	☐		☐		
Children	☐ **Sons #** _____		☐ **Daughters #** _____		

Patient Social History

Use of Tobacco:	___Never ___Previously, years quit? ___Current Packs/Day ____
Use of Alcohol:	___Never ___Rarely ___Moderate ___Daily
Use of Drugs:	___Never ___Yes, Type/Frequency_____
Exercise:	___No ___Yes, Type/Frequency_____
Caffeine:	___No ___Yes, Type/Frequency_____