**Center for Holistic Medicine**

**Wellness**

# New Patient Medical History Form

Preferred Name: ______________________________ Date: ______________________

What Pharmacy do you use? _________________________________________________

Were you referred to our office? (please circle one) Yes or No

If yes, by whom? ___________________________________________________________

**Review of Medical Symptoms**:

Currently do you have any complaints with the following. (*Please answer yes or no and complaint).*

*Constitutional:* *Fatigue, __________ Weight change, ___________ Fever, __________*

*Eyes: (Y/N) _____ Ear/Nose/Throat: (Y/N) _____ Cardiovascular (heart): (Y/N) _____*

*Skin: (Y/N) _____ Neurologic: (Y/N) _____ Respiratory (breathing): (Y/N) _____*

*Psychiatric: (Y/N) ____ Gastrointestinal: (Y/N) _____ Endocrine: (Y/N) _____*

*Allergies: (Y/N) _____ Genitourinary: (Y/N)_____ Musculoskeletal: (Y/N)_____*

*Heme/Lymphatic: (Y/N) ____*

*(bleeding, bruising etc.)*

***Medical Allergies:***

*Do you have a Latex Allergy? (Circle one) Yes / No*

*Please list all known allergies to medications and your reactions:*

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

*Patient Name:* ___________________________ *Date:* ________________________

***Medical History:***

*Have you ever been hospitalized: If yes when and why?*

_________________________________________________________________________________
_________________________________________________________________________________

Please list any current or past medical conditions you have been diagnosed with:

_________________________________________________________________________________
_________________________________________________________________________________

Have you ever been diagnosed with Cancer? If yes, when, type and treatment?

_________________________________________________________________________________
_________________________________________________________________________________

Have you ever been diagnosed with HIV/Hepatitis/Etc. Yes / No

If yes, what? ________________________________________________________

**Past Surgical History**:

Have you ever had surgery? If yes What type and When?

_________________________________________________________________________________
_________________________________________________________________________________

Have you ever had any procedures or surgeries for your heart? If yes what? ________________

**Medications**:

Please list all medication that you currently take including vitamins and non-prescription or alternative medications, the dose and frequency:

_________________________________________________________________________________
_________________________________________________________________________________
_________________________________________________________________________________
_________________________________________________________________________________
_________________________________________________________________________________
_________________________________________________________________________________

Name: ____________________________________ Date: ________________________

Have you ever had any complication with Anesthesia? Yes / No If yes, what?

________________________________________________________________________________

________________________________________________________________________________

Do you have a bleeding disorder or difficulty stopping bleeding? Yes / No ____________

**Family Medical History:**

Does any member of your immediate family (parents/siblings/children) have or have ever been treated for the following please put Y/N & who?

Bleeding Disorder: ________________________________________________________________

Complication with Anesthesia: ________________________________________________________

High Blood Pressure: ______________________________________________________________

Asthma/Emphysema: ______________________________________________________________

Heart Disease: ____________________________________________________________________

Cancer: (Type, Date, & Treatment) __________________________________________________

**Social History**:

Marital Status: Single/Married/Divorced/ widowed Number of Children____________

Who lives at home with you? ______________________________________________________

Your Occupation: _________________________________________________________________

Do you use or have you ever used Cigarettes/Cigars/Tobacco/Vape? Yes / No

Amount per day: _________ How many years? ________ Year Quit: ________

Do you drink Alcohol? Yes / No Drinks per Day: __________ Type: ___________

Do you or have you ever abused drugs: Y/N Type: ______________________________

Please Circle one: Ethnicity: African American, Asian, Caucasian, Hispanic, Other

Primary Language Spoken: _____________________________________________________