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NEW PATIENT HISTORY AND PHYSICAL

Please indicate reason for this office visit: _____

Allergies to MEDICATIONS: _____

PAST MEDICAL HISTORY: **NONE** (IF YOU HAVE NONE OF THESE BELOW, PLEASE CHECK THE BOX)

- | | | |
|---|--|--|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Coronary Artery Disease | <input type="checkbox"/> Obstructive Sleep Apnea |
| <input type="checkbox"/> Chronic Obstructive Lung Disease | <input type="checkbox"/> Diabetes -- <input type="checkbox"/> Insulin Dependent? | <input type="checkbox"/> Seizure Disorder |
| <input type="checkbox"/> Congestive Heart Failure | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> Blood Clots -- <input type="checkbox"/> Lung/Legs? | <input type="checkbox"/> Other _____ |

PAST SURGICAL HISTORY/HOSPITALIZATION(S): ****(Please list year and procedure)****

Surgery	Procedure	Year
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

SOCIAL HISTORY:

- Current alcohol use: Y N _____ # of drinks per day _____ # of drinks per week
- Street drug intake: _____
- Current # of cigarettes/day _____ Past cigarette use (# of years) _____ Interested in quitting: Y N
 NEVER SMOKED Year quit smoking: _____
- Married Single Divorced Widow

FAMILY HISTORY: (Please list disease & specify family member) i.e. Father – Diabetes

PATIENT NAME: _____ **DOB:** _____ **DATE:** _____