New Patient History

Medical History

Check all boxes that you have ever had

- ☐ Asthma
- ☐ Angina/Chest Pain
- ☐ Anemia
- ☐ Arthritis
- ☐ Glaucoma
- ☐ Cancer
- ☐ Chronic Bronchitis
- ☐ Cirrhosis
- ☐ Clotting Disorder
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Fractures
- ☐ Gall Stones
- ☐ Heart Murmur
- ☐ Heart Attack
- ☐ Headaches
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ HIV Positive/AIDS
- ☐ Kidney Disease
- ☐ Kidney Stones
- ☐ Migraines
- ☐ Positive TB Test
- ☐ Rheumatic Fever
- ☐ Stroke
- ☐ Thrombophlebitis
- ☐ Thyroid Disease
- ☐ Ulcers
- ☐ Others (please list)

HARMONY HEALTH
MEDICAL

Family History

If any of your blood relatives has ever had any of the following, please check the box. Also indicate relationship, and the relative's age, and L (living) or D (deceased).

- ☐ Bleeding & Tendency
- ☐ Cancer
- ☐ Diabetes
- ☐ Heart Attack
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Migraine Headaches
- ☐ Stroke
- ☐ Tuberculosis

Operations and/or Hospitalizations

Reason	Date	Reason	Date

Allergies to Medications: ____________________

Current Medications: ____________________

____

HARMONY HEALTH
MEDICAL

Social History

Education
- ☐ Less than 8th grade
- ☐ High School
- ☐ 2-year college
- ☐ 4-year college
- ☐ Post-graduate

Marital Status
- ☐ Single
- ☐ Married
- ☐ Domestic Partner
- ☐ Separated
- ☐ Divorced
- ☐ Widowed

Exercise Level
- ☐ None (no exercise)
- ☐ Occasional
- ☐ Moderate
- ☐ High

Caffeine
- ☐ None
- ☐ Occasional
- ☐ Moderate
- ☐ Heavy
- ☐ # of cups per day

Alcohol
Do you drink alcohol?

- ☐ Yes
- ☐ No

If yes, how often

- ☐ Occasionally
- ☐ <3 times per week
- ☐ 3+ times per week

How many drinks per week?

____

Tobacco
- ☐ Yes
- ☐ No

If not currently, did you ever use tobacco

- ☐ Yes
- ☐ No

_____ Cigarettes/day
_____ Chews/day
_____ Cigars/day
_____ # of years
_____ Years quit

Drugs
Do you currently use recreational or street drugs?

- ☐ Yes
- ☐ No

If yes, please list

____

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HARMONY HEALTH
MEDICAL

Obstetric and Gynecological History (women only)

Last PAP smear date: ______	☐ Bleeding between periods
Last Mammogram date: ______	☐ Heavy periods
Age of first menstrual period: ______	☐ Extreme menstrual pain
Date of last menstrual period or age of menopause: ______	☐ Vaginal itching, burning or discharge
	☐ Wake up in the night to go to the bathroom
Number of pregnancies: ______	☐ Hot flashes
Births: ______	☐ Breast lump or nipple discharge
Miscarriages: ______	☐ Sexually active
Abortions: ______	Current sexual partner
Cesarean Sections: ______	Male ☐ Female ☐
	Do you use condoms
	Yes ☐ No ☐
	☐ Interested in being screened for STDs