Name:________________________________

Appointment Date:________________________

New Patient Medical History

Concerns *(please rank by priority)*	Onset	Frequency	Severity
Example: Headaches	*2012*	*3-times/week*	*mild/mod/severe*

What are your goals for this visit? ____

____

____

Medical conditions (past or present) *Example: diabetes, high blood pressure, breast cancer*

What	When	What	When

Surgical Procedures/Injuries

Describe	Date	Describe	Date

Are there specific diseases that run in your immediate family?

Disease	Family Member	Disease	Family Member

What medications are you taking now? (include prescription and over-the-counter drugs)

Medication	Reason	When started	Dosage per day
____________________	______________	_______	________
____________________	______________	_______	________
____________________	______________	_______	________
____________________	______________	_______	________
____________________	______________	_______	________

What vitamins/minerals/supplements are you taking now?

Name and manufacturer	Reason	When started	Dosage/day
Ex: St John's wort (Nature's Way)	*feeling down*	*2 months ago*	*3 caps*
______________________	____________	________	_______
______________________	____________	________	_______
______________________	____________	________	_______
______________________	____________	________	_______
______________________	____________	________	_______
______________________	____________	________	_______
______________________	____________	________	_______
______________________	____________	________	_______

Allergies

Medication/Environmental	Reaction
______________________________	____________________
______________________________	____________________
______________________________	____________________

Tobacco Yes No Type & frequency ______________________________

Alcohol Yes No #drinks ______ per day/week/month *(circle one)*

Other drugs Yes No Type & frequency _______________________________

Coffee, Cola or other caffeine beverages? Yes No Type & frequency ________________

Women's Health

Age at first menstrual cycle___________ Date of last menstrual cycle___________

Date of last Pap_________ Mammogram___________ Pelvic exam________________

Number of pregnancies____________ Births_____________ Miscarriages__________

Review of Systems

Problem		System	Describe
Yes	No	Cardiovascular (chest pain, high blood pressure, fainting)	______________________
Yes	No	Respiratory (shortness of breath, wheezing)	_________________________________
Yes	No	Metabolic (thyroid, abnl blood sugars, energy level, too hot or too cold)	___________
Yes	No	Neurological (headaches, numbness, dizziness, weakness)	_____________________
Yes	No	Gastrointestinal (irregular bowel habits, cramping, heartburn)	___________________
Yes	No	Skin (rashes, itchiness, dryness)	____
Yes	No	Musculoskeletal (joint pain, muscle pain or spasm)	____________________________
Yes	No	Ears, Nose and Throat (hearing, sinus congestion, allergy)	_____________________
Yes	No	Vision (blurred, seeing double or spots)	_____________________________________
Yes	No	Difficulty sleeping, fever, weight loss/gain	__________________________________
Yes	No	Mood (anxious, depressed, stressed)	_______________________________________
Yes	No	Sexual function (low libido, impotence)	______________________________________

Please describe your typical diet:

Breakfast ____

AM Snack ____

Lunch ____

PM Snack ____

Dinner ____

Night Snack____

Do you often skip meals? _______ If yes, which one(s)? _______________________

Do you have any food intolerances or allergies?______________________________

Are there foods you crave? ____

Are there types of foods you dislike or avoid?_________________________________

What do you drink on a typical day?____

Do you use artificial sweeteners? ______ If yes, which one(s)?_________________

What type of oils do you use in your food? _________________________________

Additional comments: ____

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