NEW PATIENT MEDICAL HISTORY FORM
Mitchell, Whittaker and Wu

Name_____ Date_____

Why did you come in today?

When did this problem begin?

Have you ever had this problem before?

Are you taking any medications now? _____
What are they?

Are you allergic to any medications?

Do you or does anyone in your family have:

1) High blood pressure?	Yes_____ No_____
2) Heart disease?	Yes_____ No_____
3) Diabetes?	Yes_____ No_____
4) Kidney disease?	Yes_____ No_____
5) Thyroid disease?	Yes_____ No_____
6) Cancer?	Yes_____ No_____
7) High cholesterol?	Yes_____ No_____

Do you now or have you ever used cocaine, marijuana, LSD or heroin?

Do you belong to any of the high risk groups for AIDS?

If you do not understand any of these questions, leave them blank and we will discuss them.

I UNDERSTAND THAT MY FIRST VISIT IN THIS OFFICE IS *NOT* A PHYSICAL

_____please initial

PERSONAL AND CONFIDENTIAL

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