ADULT NEW PATIENT HISTORY

NAME:____ MRN #: ________________ DATE: ____________________________________

Fill in the blanks and check all that describe you

Chief Complaint:

(1) ____

(2) ____

Past Medical History:

Medical Diagnosis:

Surgeries:

Allergies: ____

Medications:

Family History:

	Diabetes	High Blood Pressure	High Cholesterol	Heart murmur	Kidney Failure	Cancer	Arthritis
Mom							
Dad							
Other							

Social History:

Smoking:		Never		Stopped ________Years Ago__________packs/day______years						
Alcohol:		Never		Previous user		Minimal		Moderate		Heavy
Have a Living Will:		Yes		No		Do Not Resuscitate Order				Power of Attorney
Persons in home:		Live alone		Spouse		Children		Significant Other		Parents		Siblings
Pets in Home:		Dog		Cat		Bird		Fish ☐ ______________________________		

Parents work:

	At home	Outside home	Jail
Mom			
Dad			