New Patient Medical History

Patient Information

- Name: _____
- Date of Birth: _____
- Gender: ☐ Male ☐ Female ☐ Other
- Address: _____
- City/State/Zip: _____
- Phone Number: _____
- Email: _____
- Emergency Contact Name: _____
- Emergency Contact Phone: _____
- Primary Care Physician: _____
- Date of Last Physical Exam: _____

Medical History

1. Personal Medical History (Check all that apply):

- ☐ Diabetes
- ☐ High Blood Pressure
- ☐ Heart Disease
- ☐ Stroke
- ☐ Asthma
- ☐ Cancer (Type: _____)
- ☐ Arthritis
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Thyroid Disorder
- ☐ Depression
- ☐ Anxiety
- ☐ Seizures
- ☐ Other (Please specify): _____

2. Family Medical History (Check all that apply and indicate family member):

- ☐ Diabetes (Family Member: _____)
- ☐ Heart Disease (Family Member: _____)

- ☐ Stroke (Family Member: _____)
- ☐ Cancer (Type & Family Member: _____)
- ☐ High Blood Pressure (Family Member: _____)
- ☐ Mental Health Disorders (Family Member: _____)
- ☐ Genetic Disorders (Family Member: _____)
- ☐ Other (Please specify): _____

3. Allergies (List any known allergies to medications, food, or substances):

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-

4. Current Medications (List all current medications, dosages, and frequency):

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-
-

5. Surgical History (List any past surgeries and dates):

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6. Lifestyle and Habits:

- Tobacco Use: ☐ Never ☐ Current Smoker ☐ Former Smoker (Quit Date: _____)
- Alcohol Use: ☐ Never ☐ Occasional ☐ Frequent
- Exercise: ☐ None ☐ Occasional ☐ Regular
- Diet: ☐ Poor ☐ Fair ☐ Balanced

7. Review of Systems (Check any current symptoms):

- Constitutional: ☐ Fatigue ☐ Fever

  ☐ Weight Loss ☐ Weight Gain
- Cardiovascular: ☐ Chest Pain ☐ Palpitations

  ☐ Shortness of Breath
- Respiratory: ☐ Cough ☐ Wheezing ☐ Difficulty Breathing

- Gastrointestinal: ☐ Nausea ☐ Vomiting

  ☐ Abdominal Pain ☐ Diarrhea
- Neurological: ☐ Headaches ☐ Dizziness

  ☐ Numbness ☐ Seizures
- Psychiatric: ☐ Anxiety ☐ Depression

  ☐ Mood Swings ☐ Difficulty Sleeping

8. Additional Comments or Concerns:

PATIENT CONSENT**

I,_____, give permission to INTEGRATIVE WELLNESS CLINIC Staff to leave messages concerning appointments, referral and test results to _____ (specify the relationship to you: Spouse, parent, sibling... etc)

Digital Voice Message Consent:

I DO / DO NOT (circle one) give permission for the staff to leave medical information (test results I appt. times) on my answering machine provided at the phone numbers given on my patient account information.

**Please be advised that the Medical Staff will not discuss your personal medical information in detail with any family member or friend of the family.

Signature

By signing below, I confirm that the above information is correct to the best of my knowledge.

Signature: _____

Date: _____