Grace Internal Medicine

New Patient History Form

Name: _____ **Date of Birth:** _____

Medical History: Check any of the following medical conditions that apply to you or your family.

Condition	Self	Mother	Father	Sibling
Alcoholism				
Allergies				
Anemia				
Aneurysm				
Asthma				
Back pain				
Blood Clot				
Cancer				
Heart Failure				
Depression				
Diabetes				
Diverticulosis				
Glaucoma				
COPD				
Seizures				
Hx of illicit drug use				

Condition	Self	Mother	Father	Sibling
Acid Reflux				
Heart Attack				
Hepatitis				
High blood pressure				
High Cholesterol				
Kidney Stones				
Migraine				
Osteoporosis				
Prostate Enlargement				
Stroke				
Thyroid disease				
Sleep Apnea				

Other medical conditions that you have been diagnosed with:

Surgical History:

1. _____ 2. _____ 3. _____

2. _____ 6. _____ 6. _____

Allergies:

1. _____ 4. _____ 3. _____

2. _____ 5. _____ 6. _____

Current Medications: Include any vitamins, herbs, and over the counter medications you are taking.

Medication Name	Dosage	Frequency

Social History: Check all that apply to you. Note how much per day and for how long when appropriate.

- Current/Past Alcohol use _____
- Chew Tobacco _____
- Current/Past Drug use _____
- Regular Exercise _____
- Current/Past Smoking _____

Occupation: _____

Religion: _____

Immunization	Date
Pneumonia	
Flu	
Tetanus	
Hepatitis B	
COVID	

Prevention	Date
Colonoscopy	
Mammogram	
Pap Smear	
Bone Density	