NP MED
CORNERSTONE HEALTH & FAMILY PRACTICE
NEW PATIENT MEDICAL HISTORY

Patient Name_____Age:_____Date_____

What medications are you allergic to?_____

Please list all medications that you take and dosage. Include over - the counter medications, vitamins and herbal medication: _____
_____
_____

What surgeries have you had and when?_____
_____

Do you smoke?_____ If yes, how many cigarettes or packs per day?_____

Do you drink alcohol?_____ If yes, how many drinks per week?_____

Do you use street drugs? _____ If so, what kind?_____

Do you work? _____ What kind of work do you do?_____

Who do you live with?_____

When was your last pap ?_____ Your last mammogram_____

When was your last colonoscopy? _____

DO YOU HAVE A FAMILY HISTORY OF:

Heart attack? Yes / No If yes, what family member?_____
Stroke ? Yes / No If yes, what family member?_____
Cancer? Yes / No If yes, what family member?_____
Where was the cancer located?_____

Diabetes? Yes / No If yes, what family member?_____
Asthma? Yes / No If yes, what family member?_____
Clotting Disorder Yes / No If yes, what family member?_____
High Blood Pressure? Yes / No If yes, what family member?_____

Do you have a Medical Power of Attorney? ____Yes____No Living Will? ____Yes_____No
We offered a combined Power of Attorney/Living Will, would you like to make one? Yes____No____