Solutions medical center
aesthetics, wellness & weight loss

New Patient Health History Form

Date_____
Name_____ **Gender** M F **Age**_____ **Date of Birth**_____
Address_____ **City**_____**State**_____ **Zip**_____
Home Phone_____**Work Phone**_____**Cell Phone**_____
Email Adress_____
How did you hear about our clinic?_____

Please list your current medications AND supplements:

Please list your medication allergies:

☐ Check this box if you have **NO** MEDICATION ALLERGIES

Past Medical History: Do you have any of the following?		
Diabetes Yes__ No__ Comments:	**Arthritis** Yes__ No__ Comments:	**Gallbladder** Yes__ No__ Comments:
High Blood Pressure Yes__ No__ Comments:	**Osteoporosis** Yes__ No__ Comments:	**Hepatitis/Liver** Yes__ No__ Comments:
Heart Attack/Disease Yes__ No__ Comments:	**Fractures** Yes__ No__ Comments:	**Pacemaker** Yes__ No__ Comments:
High Cholesterol Yes__ No__ Comments:	**Incontinence** Yes__ No__ Comments:	**Joint Problems** Yes__ No__ Comments:
IBS Yes__ No__ Comments:	**Kidney Disease** Yes__ No__ Comments:	**Cancer** Yes__ No__ Comments:
Anorexia Yes__ No__ Comments:	**Back/Neck Problems** Yes__ No__ Comments:	**Depression/Anxiety** Yes__ No__ Comments:
COPD Yes__ No__ Comments:	**Thyroid Disorder** Yes__ No__ Comments:	**Psychiatric Disorders** Yes__ No__ Comments:
Obesity Yes__ No__ Comments:	**Tuberculosis** Yes__ No__ Comments:	**Alcoholism** Yes__ No__ Comments:
Emphysema Yes__ No__ Comments:	**Stroke** Yes__ No__ Comments:	**Insomnia** Yes__ No__ Comments:
Allergies Yes__ No__ Comments:	**Blood Clots** Yes__ No__ Comments:	**Smoke** Yes__ No__ Packs/day_____
Aneursym Yes__ No__ Comments:	**Varicose Veins** Yes__ No__ Comments:	**Other** Comments:

Sexual History (FOR FEMALES ONLY)	
Are you pregnant? Yes__ No__ Unsure__	Last Colonoscopy: normal___abnormal___
Last menstrual period:	Hormone Replacement Therapy: Yes__ No__
Length of normal period:	Birth Control Method:
Age of first period:	How many Pregnancies:_____ Deliveries: _____ Abortions: _____ Miscarriages:_____
Age of menopause (if applicable):	Sexually Active: Yes___ No___ # of current partners?_____
Abnormal vaginal bleeding: Yes__ No__	Your Partner is: Male____ Female_____ Both_____
Last Pap Smear: Date:_____ normal___abnormal___	STDs: Herpes__ Gonorrhea__ Chlamydia__HPV__ Syphilis___
Last Mammogram: Date:_____ normal___abnormal___	Infections: Yeast__Bacterial Vaginosis__ PID__ Discharge___
Last Bone Density: normal___abnormal___	Other:

Sexual History (FOR MALES ONLY)	
Last Prostate Exam: normal___abnormal___	Testicular Lumps: Yes__ No__ Comments:
Last Colonoscopy: normal___abnormal___	Penile Discharge: Yes__ No__ Comments:
Last PSA:	Your Partner is: Male____ Female_____ Both_____
Vasectomy: Yes__ No__ Comments:	STDs: Herpes__ Gonorrhea__ Chlamydia__HPV__ Syphilis___
Erectile Dysfunction: Yes__ No__ Comments:	Other:

Past Surgical History/Hospitalizations:		
Surgical Procedure:	Year:	Reason:

Have any members of your family had the following?

	Father	Mother	Sibling	Grandparent	Cause of Death (if applicable)	Age at Death
Alcoholism						
Anemia						
Sickle Cell Disease						
Asthma						
Bronchitis						
Emphysema						
Pneumonia						
Tuberculosis						
Arthritis/Gout						
Blood Transfusions						
Cancer						
Diabetes						
Gallbladder Disease						
Heart Murmur						
Heart Disease						
Hepatitis						
Colitis						
High Blood Pressure						
Kidney Disease/Stones						
Urinary Infections						
Mental Illness						
Seizures						
Stroke						
Ulcers						
Glaucoma/Blindness						
Migraines						
Thyroid Disease						