HOPEHEALTH
YOUR HEALTH BEGINS HERE

New Patient Medical History

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

Name of Physician last seen: _____ Date of last visit: _____

Reason you were seen: _____

Why are you seeking a new provider? _____

Is this visit a result of a work injury? ☐ No ☐ Yes Is this visit a result of a car accident? ☐ No ☐ Yes

Please describe the reason for this visit: _____

Medical Conditions

Do you have any allergies? ☐ No ☐ Yes If yes, please list: _____

Have you been diagnosed with any conditions that require you to take medication daily? ☐ No ☐ Yes

If so, please list the diagnoses/condition(s):

1	5
2	6
3	7
4	8

Please list any medications that you take on a daily basis.

1	5
2	6
3	7
4	8

Are you on a controlled substance? ☐ No ☐ Yes Are you will to see pain management/behavioral health for controlled medication needs? ☐ No ☐ Yes

Please list any surgeries you have had:	**Date of Surgery**

Date of Last Hospitalization: _____ Reason: _____

Do you have an Advanced Directive/Living Will? ☐ Yes ☐ No

Have you ever been diagnosed with: ☐ STD ☐ Hepatitis B ☐ Hepatitis C ☐ HIV

Have you ever been treated for mental health issues? ☐ No ☐ Yes If yes, please describe: _____

Social History

Do you/Have you:				**Type**	**How many/often?**
Smoke	☐ Yes	☐ No	☐ In the past		
Drink alcohol	☐ Yes	☐ No	☐ In the past		
Drink Caffeine	☐ Yes	☐ No	☐ In the past		
Use Drugs	☐ Yes	☐ No	☐ In the past		
Have pets in the home?	☐ Yes	☐ No			
Been a victim of child abuse?	☐ Yes	☐ No		Been a victim of Domestic Violence?	☐ Yes ☐ No
Been convicted of a crime/imprisonment?	☐ Yes	☐ No		Been a victim of Sex Trafficking?	☐ Yes ☐ No
Traveled outside the US within the last 6 months or year?	☐ Yes	☐ No			

Is there any other information you feel your provider should know?

Patient Signature _____ Date _____