

# New Patient Medical History Form

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Reason you are here: \_\_\_\_\_

**Personal Medical History:** Have you ever had any of the following conditions? (Check if yes)

|  |   |  |
|--|---|--|
| <input type="checkbox"/> Anemia                                | <input type="checkbox"/> Crohn's Disease    | <input type="checkbox"/> HIV/AIDS              |
| <input type="checkbox"/> Arthritis                             | <input type="checkbox"/> Depression         | <input type="checkbox"/> Hypertension          |
| <input type="checkbox"/> Asthma                                | <input type="checkbox"/> Diabetes           | <input type="checkbox"/> Kidney Disease        |
| <input type="checkbox"/> Cancer                                | <input type="checkbox"/> Emphysema          | <input type="checkbox"/> Myocardial Infarction |
| <input type="checkbox"/> Chronic Obstructive Pulmonary Disease | <input type="checkbox"/> Endocrine Problems | <input type="checkbox"/> Peptic Ulcer Disease  |
| <input type="checkbox"/> Clotting Disorder                     | <input type="checkbox"/> GERD               | <input type="checkbox"/> Seizures              |
| <input type="checkbox"/> Congestive Heart Failure              | <input type="checkbox"/> Glaucoma           | <input type="checkbox"/> Stroke                |
|  | <input type="checkbox"/> Hepatitis          | <input type="checkbox"/> Ulcerative Colitis    |

**Personal Surgical History:** Have you ever had any of the following surgeries? (Check if yes)

|  |   |  |
|--|---|--|
| <input type="checkbox"/> Adrenal Gland Surgery | <input type="checkbox"/> Colon Surgery                | <input type="checkbox"/> Kidney Surgery          |
| <input type="checkbox"/> Appendectomy          | <input type="checkbox"/> Coronary Artery Bypass Graft | <input type="checkbox"/> Neck Surgery            |
| <input type="checkbox"/> Bariatric Surgery     | <input type="checkbox"/> Esophagus Surgery            | <input type="checkbox"/> Prostate Surgery        |
| <input type="checkbox"/> Bladder Surgery       | <input type="checkbox"/> Gastric Bypass Surgery       | <input type="checkbox"/> Small Intestine Surgery |
| <input type="checkbox"/> Breast Surgery        | <input type="checkbox"/> Hemorrhoid Surgery           | <input type="checkbox"/> Spine Surgery           |
| <input type="checkbox"/> Cesarean Section      | <input type="checkbox"/> Hernia Repair                | <input type="checkbox"/> Stomach Surgery         |
| <input type="checkbox"/> Cholecystectomy       | <input type="checkbox"/> Hysterectomy                 | <input type="checkbox"/> Thyroid Surgery         |

List names and dates of surgeries: \_\_\_\_\_

\_\_\_\_\_

**Medications:** \_\_\_\_\_

\_\_\_\_\_

**Allergies:** \_\_\_\_\_

\_\_\_\_\_

**Family History:** Has anyone in your family had any of the following conditions? (Check if yes, and indicate relationship to you)

|  |   |  |
|--|---|--|
| <input type="checkbox"/> Cancer/Polyps<br>Colon, Rectum, Anal, Stomach, Breast,<br>Prostate, Uterus, Ovaries, Thyroid, Lung,<br>Blood, Lymphoma<br>Other _____ | <input type="checkbox"/> Anemia _____<br><input type="checkbox"/> Diabetes _____<br><input type="checkbox"/> Blood Clots _____<br><input type="checkbox"/> Heart Disease _____<br><input type="checkbox"/> Stroke _____ | <input type="checkbox"/> High Blood Pressure _____<br><input type="checkbox"/> Anesthesia Reaction _____<br><input type="checkbox"/> Bleeding Problems _____<br><input type="checkbox"/> Hepatitis _____<br><input type="checkbox"/> Other _____ |
|--|---|--|



# Medical History Template

**JS Bruner**





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## **Table of Contents Medical History Template**

1. Understanding the eBook Medical History Template
  - The Rise of Digital Reading Medical History Template
  - Advantages of eBooks Over Traditional Books
2. Identifying Medical History Template
  - Exploring Different Genres
  - Considering Fiction vs. Non-Fiction
  - Determining Your Reading Goals
3. Choosing the Right eBook Platform
  - Popular eBook Platforms
  - Features to Look for in an Medical History Template
  - User-Friendly Interface
4. Exploring eBook Recommendations from Medical History Template
  - Personalized Recommendations
  - Medical History Template User Reviews and Ratings
  - Medical History Template and Bestseller Lists
5. Accessing Medical History Template Free and Paid eBooks



- Medical History Template Public Domain eBooks
- Medical History Template eBook Subscription Services
- Medical History Template Budget-Friendly Options
- 6. Navigating Medical History Template eBook Formats
  - ePub, PDF, MOBI, and More
  - Medical History Template Compatibility with Devices
  - Medical History Template Enhanced eBook Features
- 7. Enhancing Your Reading Experience
  - Adjustable Fonts and Text Sizes of Medical History Template
  - Highlighting and Note-Taking Medical History Template
  - Interactive Elements Medical History Template
- 8. Staying Engaged with Medical History Template
  - Joining Online Reading Communities
  - Participating in Virtual Book Clubs
  - Following Authors and Publishers Medical History Template
- 9. Balancing eBooks and Physical Books Medical History Template
  - Benefits of a Digital Library
  - Creating a Diverse Reading Collection Medical History Template
- 10. Overcoming Reading Challenges
  - Dealing with Digital Eye Strain
  - Minimizing Distractions
  - Managing Screen Time
- 11. Cultivating a Reading Routine Medical History Template
  - Setting Reading Goals Medical History Template
  - Carving Out Dedicated Reading Time
- 12. Sourcing Reliable Information of Medical History Template
  - Fact-Checking eBook Content of Medical History Template
  - Distinguishing Credible Sources
- 13. Promoting Lifelong Learning
  - Utilizing eBooks for Skill Development



- Exploring Educational eBooks

### 14. Embracing eBook Trends

- Integration of Multimedia Elements
- Interactive and Gamified eBooks

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