Brazosport Regional
FAMILY MEDICINE CENTER

New Patient History

Your answers on this form will help your health care provider get an accurate history of your medical concerns and conditions. Please fill in all pages. If you cannot remember specific details, please provide your best guess. If you are uncomfortable with any question, do not answer it. Thank you!

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

Ethnicity: _____

Learning style (circle one) **Visual** **Written** **Verbal** **Other**

Preferred language/type of communication: _____

Why are you seeing the doctor today? _____

Medical History:

Please circle any of the following conditions you have had:

Abnormal heart rhythm	Allergies	Anxiety	Asthma
Bipolar disorder	Cancer	Circulation problems	COPD / Emphysema
CHF	Depression	Diabetes	Diverticulitis
Erectile dysfunction	Gallstones	Hepatitis	Heart disease
High cholesterol	High blood pressure	Irritable bowel	Kidney disease
Kidney stones	Memory problems	Migraines	Osteoporosis /Osteopenia
Prostate problems	Reflux	Seizures	Sinus problems
Stroke	Swelling	Thyroid problems	Ulcers

Surgical History:

Type of Surgery	Year	Why?

Allergies:

Medication	What type of reaction?

Tobacco Use(circle): Never Quit Current

If current tobacco use, what type and how often? _____

How often do you have alcoholic beverages? _____

Have you ever used and recreational drugs? If so, what type? _____