Caring for the Family
Jan Hester, MD

New Patient Health History Date:_____

Patient Name:_____ DOB:_____

Marital Status:_____ Occupation:_____

Social Security #_____ Reason for appointment:_____

Current/Chronic Health Issues:_____

Current Medications (include dosage):_____

_____

Supplements:_____

Known Drug Allergies:_____

Preferred Pharmacy (include location):_____

Emergency Contact:_____
Telephone:_____ Relationship:_____

Hospital Admission/Surgeries: Year _____ Surgery/Reason _____

_____

_____

_____

Current or Former Medical Issues Involving:

Eyes, Ears, Nose or Throat:_____ Respiratory:_____

Cardiac:_____ Gastrointestinal:_____

Genitourinary:_____ Psychiatric:_____

Musculoskeletal:_____ Neurologic:_____

Endocrine:_____ Sexual:_____

Do you exercise: Y/N Exercise performed:_____ Frequency:_____

Tobacco Use: Y/N Age of Onset:_____ Frequency:_____ Year Quit:_____

Alcohol Use: Y/N Frequency:_____ Drugs:_____

Family History: Name **Living/Deceased** **Cause of Death** **Hereditary Illnesses**

Father:_____

Mother:_____

Sisters/Brothers:_____

_____

_____

Children:_____

_____

_____

_____

Spouse:_____

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