New Patient Information

Patient Name: (last) _____ (first) _____ (MI) _____
Sex: _____ Date of Birth: _____ Age: _____ Height: _____Weight: _____

Who is your Primary Care Physician? _____

List the PRESCRIPTIONS you are currently taking

Name	Dose (mg, mcg, etc.)	Frequency and the time you take it	Prescribing doctor
–			
–			
–			
–			
–			
–			
–			
–			
–			
–			

List the SUPPLEMENTS and over-the-counter meds you are currently taking
Note: please bring all supplement bottles to your initial office visit

Name	Dose (mg, mcg, etc.)	Frequency and the time you take it
–		
–		
–		
–		
–		
–		
–		
–		

There is more space at the bottom of the second page, if you need it

To what drugs are you allergic? _____

Medical History:
For what medical problems do you need treatment? (*For examples, check "Family History" below*)

–	–
–	–
–	–
–	–

Allergy: Have you even been tested? No / Yes. If so, when? _____ By Doctor _____
Are you currently on allergy shots or drops? No / Yes
Have you ever taken allergy shots or drops? No / Yes If so, when? _____

Operations: *List procedure, how old you were, the reason for the operation and any complication*

–	–
–	–
–	–
–	–

Injuries: *Note any fractures or traumatic physical injuries and whether lingering problems resulted (Example: Rear-ended in auto accident and chronic pain from whiplash injury)*

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–

Family History: *Please circle any illness suffered by your close, "blood"-relatives including your grandparents, parents, aunts and uncles, brothers and sisters and your children*

Diabetes	Low blood sugar	Sinus problems	Thyroid problems
High blood pressure	Ovarian cysts	Headaches	Anemia
High cholesterol	Uterine fibroids	Ear infections	Bleeding problems
Heart problems	Fibrocystic breasts	Hearing loss	Psychiatric problems
Stroke	Problems with hair	Asthma	Cancer (of what?)
Sleep apnea	Obesity	Lung problems	Other:

Social History:
What is your occupation? _____ For how long? _____

Have you had any job-related exposure to (*Please circle*): Chemicals / Noise / Other: _____

Do you drink alcoholic beverages? No / Yes If so, please give details:

Do you smoke? If so, note how much of what:
If you've ever smoked, how much? _____Pks/day x _____ years

Does anyone in your family smoke? No / Yes Is smoking allowed in your home? No / Yes

Do you use any substances not noted above? No / Yes If so, what? _____
(*Just so you know: I'm not the Cops, this is confidential and it is your health*)

Who referred you to our practice?

Thanks for your efforts! Samuel L. Moltz, M.D.

Additional Information

Diet-*please list typical food selections throughout the day:*
Breakfast:

_____
_____

AM Snack:

_____

Lunch:

_____
_____

Afternoon Snack:

_____

Dinner:

_____
_____

Evening Snack:

_____

Beverages (including juices, energy drinks, caffeine):

_____
_____

Known/suspected intolerance of specific foods:

_____
_____

Digestion: *Please describe any digestive issues (ie. diarrhea/constipation, heartburn, bloating/distention/ flatus, softer unformed stools) and any medications/over the counter products utilized:*

_____
_____
_____

Energy: *Do you ever feel fatigue? If so, please indicate if there is a typical daily pattern (ie. more prominent in am, mid afternoon):*

_____
_____

Sleep: *Any problems getting to sleep or staying asleep? Snoring issues? Inability to achieve deep sleep? Please list any sleep aids that are utilized:*

_____
_____

Antibiotics: *Have you ever used antibiotics for a sustained period of time? (More than 1-2 weeks at a time? More than once a year?)*
If yes, please indicate reason, type of antibiotic, frequency and duration.
If no, please indicate frequency of antibiotic use over the past 3-5 years.

_____
_____

Dental: *Any history of dental fillings, amalgam type (if known); have fillings ever been removed/ exchanged*

_____
_____