Longmont Clinic New Patient Form

Name______________________________ Which Doctor are you seeing today?_________________
Today's Date____________________ Age____________ Date of birth_________________________
Who referred you to our office?____
Why are you seeing the doctor today? ____

Personal Health History (Please include dates)

Surgeries **Illness / Disease**

___________________ ___________________ ___________________ __________________
___________________ ___________________ ___________________ __________________
___________________ ___________________ ___________________ __________________
___________________ ___________________ ___________________ __________________

List Allergies and / or adverse reactions to all medication__________________________________

List Current Medications

Medication	Dose / Frequency	Medication	Dose / frequency

Family Health History

Current Age & State of Health	**or**	**Age of death & cause**
Father: ________________________________		____________________________________
Mother: ________________________________		____________________________________
Sisters: ________________________________		____________________________________
________________________________		____________________________________
________________________________		____________________________________
________________________________		____________________________________
________________________________		____________________________________
Brothers: ________________________________		____________________________________
________________________________		____________________________________
________________________________		____________________________________
________________________________		____________________________________
________________________________		____________________________________

Do any other family members have cancer or any other serious illnesses? _________________________________
Marital Status? Married, Divorced, Separated, Widowed, or single (please circle one)
Occupation ___________________________
Do you smoke? _________________ If yes how much? ____________________ How often? _________________
Do you drink alcohol? _____________ If yes how much? __________________ How often? _________________
Do you now, or have you ever used street drugs? ____

Please circle all that apply:

Heart Disease	Autoimmune-Arthritis	Kidney Disease	Thyroid Problems
Seizures / Epilepsy	Liver Problems	Bowel problems	Lung Disease
Skin problems	Allergies	Hearing / Vision	
Cancer	Anemia	Urinary Problems	