MAINE OSTEOPATHIC HEALTH

New Patient Form

First Name:_____ Last Name: _____ DOB:_____

Preferred Name: _____ Pronouns: _____

Address: _____

City:_____ State: _____ Zip Code: _____

Primary Care Physician: _____

Reason for today's visit: _____

Medical History

Please list all allergies:_____

_____

Please list all medications you are taking, including dose and frequency:_____

_____

_____

Please list all medical problems: _____

_____

_____

_____

Please list any surgeries:_____

_____

_____

_____

Social History

Do you smoke/chew tobacco? If yes, how many packs per day? _____

Do you drink alcohol? If yes, how many drinks per week? _____

Do you use marijuana? If yes, how much and how often? _____

Do you use any illicit drugs? If yes, what type and how often? _____

Do you drink caffeine? If yes, how much per day?_____

Marital Status: _____ Occupation: _____

Do you have any children? _____ If yes, how many? _____

Family History

Father - Health Problems: _____

Mother - Health Problems: _____

Maternal Grandmother : Health Problems: _____

Maternal Grandfather : Health Problems: _____

Paternal Grandmother : Health Problems: _____

Paternal Grandfather : Health Problems: _____

# of Brothers - _____ Health Problems:_____

# of Sisters - _____ Health Problems:_____

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