MAINE OSTEOPATHIC HEALTH

New Patient Form

First Name:_____ Last Name:_____ DOB:_____
Preferred Name: _____ Pronouns: _____ Last 4 Numbers of SS: __XXX-XX-_____
Address: _____
City: _____ State: _____ Zip Code:_____
Phone Number:_____ Email: _____
Primary Care Physician Name:_____
Primary Care Physician Address:_____

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, ho 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: _____

Maine Osteopathic Health
700 Mount Hope Avenue, Suite 600
Bangor, Maine 04401
Phone: 207-922-2464
Fax: 207-922-2463