MD TruCare
Psychiatry, Endocrinology and Sleep Medicine

New Patient Medical History Form

Patient Name_____**DOB**_____**Age**_____

Reason for Visit:_____

Medications:

1._____**Dose**_____

2._____**Dose**_____

3._____**Dose**_____

4._____**Dose**_____

5._____**Dose**_____

6._____**Dose**_____

***<u>If you have any more medications, please bring your medication list to your appointment</u>

Allergies: _____

Social History:

Do you smoke? ◯ **Yes** ◯ **No** **Current Smoker:** _____ **Packs/Day**

Former Smoker: Quit Date_____

Do you drink alcohol? ◯ **Yes** ◯ **No** **Number of Drinks per week**_____

Marital Status: ☐ **Single** ☐ **Married** ☐ **Separated** ☐ **Divorced** ☐ **Widowed** ☐ **Partner**

Do you have children? ◯ **Yes** ◯ **No** **If yes, how many?** _____

Occupation_____

Family History

	Diabetes	Hypertension	High Cholesterol	Heart Disorder	Thyroid Disorder	Other
Mother						
Father						
Paternal Grand Mother						
Paternal Grand Father						
Maternal Grand Mother						
Maternal Grand Father						
Siblings						

Surgical History:

Date: **Type:**

Date: **Type:**