VIRGINIA INSTITUTE
OF FAMILY MEDICINE

NEW PATIENT MEDICAL HISTORY FORM

Patient Name: _____ **Date of Birth:** _____

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1. Past Medical History

Please check all that apply — even if the condition is controlled or resolved — and add other diagnoses as needed:

☐ Diabetes (Type I / Type II)
☐ High Cholesterol
☐ High Blood Pressure
☐ Stroke
☐ Heart disease / Congestive Heart Failure
☐ Depression / Anxiety
☐ Myocardial Infarction
☐ Other Mental Illness: _____
☐ Coronary Artery Disease
☐ Arthritis
☐ Asthma
☐ Autoimmune Disorder
☐ Thyroid Disorder
☐ Cancer (type: _____)
☐ Kidney Disease
☐ Alzheimer's Disease

Other Diagnoses:

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2. Medications (Use the back of this for additional meds if needed…)

List all prescription and over-the-counter medications, vitamins, and supplements you currently take:

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3. Surgical History

List all past surgeries and approximate year:

4. Allergies

List all medication, food, or environmental allergies and your reaction:

Allergy *Reaction*

☐ No Known Drug Allergies (NKDA)
☐ Food Allergies: _____
☐ Latex Allergy

5. Additional Notes

I attest that the above medical history and information is complete and accurate to the best of my knowledge.

Signature: _____ Date: _____

THANK YOU!