



New Perspectives Health Care

13A Main Street, Suite 7

Sparta, New Jersey 07871

973.726.0355

www.newperspectiveshealthcare.com

Today's DATE: _____

NAME OF PATIENT: _____ **Date of Birth:** _____ **Male/Female**

Health History/Your own issues with:

- Alcohol/drug Abuse
- Anemia
- Arthritis
- Asthma
- Bronchitis/Sinus
- Cancer
- Chest Pain
- Diabetes
- Ear/Hearing
- Eating disorder
- Fatigue
- Genetic disorder
- Headaches
- OTHER
- Head Injury/Stroke
- Heart Issues
- Hepatitis
- High Blood Pressure
- HIV/Aids
- Kidney
- Lipid/Cholesterol
- Liver
- Lyme
- Menstrual
- Migraines
- Muscle issues
- Nausea/Vomiting
- Occupational exposure
- Osteoporosis
- Pneumonia
- Psychological issues (depression/anxiety irritable, poor concentration, etc)
- Rheumatic Fever
- Seizure disorder
- Sexual Dysfunction/Issues
- Sexually Transmitted Diseases
- Skin issues
- Stomach/Intestinal issues
- Sleep issues
- Thyroid
- Transfusion of blood
- Urinary issues
- Weight changes/Appetite changes

Comments/details: _____

Tobacco: Yes/No; ___ Packs/day; _____ # of years smoked; ___ Type: _____ QUIT YEAR: ___
(such as cigarettes; cigarillos; chewing tobacco; pipe, cigar; bidis; etc)

Alcohol: Yes/No: _____ amount; _____ frequency (daily, weekly, monthly)

Recreational Drugs: Yes/No: ___ Kind of drug: _____ (Pot, Ecstasy, Heroin, etc)

Caffeine intake: coffee/tea/chocolate/soda: _____ how many cups/servings per day

Allergies to Medications: _____

Allergies to environment: _____

Medications taken Regularly, both prescription and over the counter/include vitamins, aspirin and alternative medicine:

Name of Drug	Dose	Frequency	Name of Drug	Dose	Frequency

Surgical History: Type of surgery _____ Date of Surgery _____ Where _____

Gynecology History (For Women Only)

Number of Pregnancies: _____ Age at first period: _____ Last Period: _____

Last Pap smear: _____ Last Mammogram: _____

Number of live births: _____ Hormone use: _____ (birth control pills, HRT, etc)

Miscarriages: _____ Terminations: _____ Did you breast feed? _____ For how long: _____

Last Eye Exam: _____ Last Dental exam: _____ Last Tetanus shot: _____

Family History: (include things like: high blood pressure, cholesterol, diabetes, cancers, etc)

	Alive/Deceased	Age	Health Issues
Father			
Mother			
Son			
Son #2			
Son #3			
Daughter			
Daughter#2			
Daughter#3			
Paternal Gpa			
Paternal Gma			
Maternal Gpa			
Maternal Gma			
Paternal Uncle			
Paternal Aunt			
Maternal Uncle			
Maternal Aunt			

Brother			
Brother #2			
Brother #3			
Brother #4			
Sister			
Sister #2			
Sister #3			
Sister #4			
Cousins			
Spouse			

OTHER INFORMATION YOU'D LIKE TO SHARE:
