New Perspectives Health Care
13 A Main Street, Suite 7
Sparta, NJ 07871
973.726.0355
www.newperspectiveshealthcare.com

Name of Patient: _____
Date of Birth: _____
Male / Female

Today's Date: _____

New Patient History Form

Current Medications/Vitamins/Supplements:

Name	Dose and Frequency	Name	Dose and Frequency

Personal Health History (Past and Current):

- ◯ Arthritis
- ◯ Asthma/COPD Bronchitis
- ◯ Cancer: type:
- ◯ Diabetes/ elevated sugars
- ◯ Genetic disorder:
- ◯ Heart Issues
- ◯ High blood pressure
- ◯ Kidney issues
- ◯ High cholesterol
- ◯ Liver issues
- ◯ Menstrual Issue
- ◯ Migraines/ Headaches
- ◯ Osteoporosis
- ◯ Depression/Anxiety/ Insomnia/ADD
- ◯ Sexual dysfunction/issues
- ◯ Thyroid issues
- ◯ Urinary issues
- ◯ Weight gain/loss

Any additional history or comments:

Allergies/Intolerances (Medications, environmental, food, seasonal) and **reaction type**

For women:

Gynecological

Periods - regular/irregular
Last pap smear - _____
Last mammogram - _____
Abnormal pap results? _____
Last period - _____
Hormone use (includes Birth control/IUDs) -_____
Age of first period - _____

Obstetric History

# of pregnancies _____
live births _____
of stillbirths _____
# of miscarriages _____
termination/abortion _____
of C-sections _____
Breastfeed? Yes or No, How long?

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

Surgical History:

Date	Type

Family History (such as: high blood pressure, cholesterol, diabetes, cancers, genetic disorders, etc):

	Alive/Deceased	Year of birth	Health Issues
Father			
Mother			
Daughter			
Daughter #2			
Daughter #3			
Son			
Son #2			
Son #3			
Paternal GF			
Paternal GM			
Maternal GF			
Maternal GM			
Paternal Uncle(s)			
Paternal Aunt(s)			
Maternal Uncle(s)			
Maternal Aunt(s)			
Sister			
Sister #2			
Sister #3			
Sister #4			
Brother			
Brother #2			
Brother #3			
Brother #4			
Spouse			

Social History:

Living will/Advance directive Yes or No (If yes, please bring a copy for our records)
Recreational drug use Y/N Type _____ Frequency _____ Quit year _____
Previous primary care provider _____
Alcohol use Y/N Amount _____Frequency _____
Caffeine use Y/N Type: Coffee, tea, soda, chocolate, energy drinks Amount/day _____
Occupation _____
Tobacco use Y/N Packs/day _____ #years smoked _____ Type _____ Quit year _____
Vaping use Y/N #years used _____ Type _____ Quit year _____

Preventive Care:

Last Annual exam _____ Eye exam_____ Dental exam_____
Flu vaccine_____ Tetanus_____ Shingles vaccine_____
Pneumonia vaccine_____ Colonoscopy_____ Bone density _____

Additional Info: