Boston Mountain Rural Health Center, Inc.

NEW PATIENT HISTORY FORM

To our new patients: To help us establish you with our practice, please provide us with your complete health history.

Personal History (Patient) **Date:** _____

Name: _____ Date of Birth____/____/_____(mm/dd/yyyy) Age_____

PERSONAL AND FAMILY HISTORY

Check those that apply:

	Yourself	Mother	Father	Grandparents	Sister/ Brother	Spouse	Children
AIDS							
Alcoholism							
Allergies							
Alzheimer's							
Anemia							
Arthritis							
Asthma							
Birth Defects							
Bleeding Disorder							
Breast Cancer							
Cancer							
Colon Cancer							
COPD							
Depression							
Diabetes							
Emphysema							
Epilepsy							
Glaucoma							
Heart Attack							
Heart Trouble							
High Blood Pressure							
IBS							
Kidney Disease							
Liver Disease							
Mental Illness							
Migraine Headaches							
Pneumonia							
Prostate Cancer							
Sickle Cell Anemia							
Stroke							
Suicide							
Tuberculosis							
Ulcers							
Other							

ALLERGIES: Like – Food, Pollens, Odors, Medicines, Pets etc...

_____

_____

Current Medications	**Dose**	**Times / Day**
Current Herbs / Vitamins/ Homeopathy/ Supplements	**Dose**	**Times / Day**

PAST MEDICAL, SURGICAL & TRAUMA HISTORY **Patient Name:**

List prior illness, injury, hospitalization, surgery, and/or trauma:

Reason: **Date/Month and Year**

_____

_____

This history record has been designed to facilitate our patients to assess their health issues in detail.

_____

Date Patient/ Guardian signature that filled out the history