Todd S.
HARRIS, MD

New Patient Medical History

1. **Name:** _____

Date of Birth: _____ Height: _____ Weight: _____

Pharmacy Name: _____ Pharmacy Address: _____

2. **Reason for today's visit?** _____

3. **Do you have any allergies**?

☐ No ☐ Yes

(Please include allergies or sensitivities to drugs, foods, environment, or latex)

If yes, include medication & reaction: _____

_____

4. **Medical History** (Please mark all that apply) :

☐Anxiety
☐Asthma
☐Bleeding Disorder
☐Blood Disease
☐Cancer: _____
☐Chipped/Loose Teeth
☐Diabetic
☐Emphysema
☐Family History of Anesthesia Problem
☐Heart Disease
☐High Blood Pressure
☐Hyperlipidemia
☐Infectious Disease
☐Kidney Disease
☐Liver Disease
☐Major Depression
☐Neurologic Disorder
☐Pulmonary (Lung) Disease
☐Shortness of Breath
☐Sleep Apnea
☐Stroke
☐Thyroid Disorder
☐Other Psychiatric Disorder Or Significant Illness?
Please List: _____
_____
_____

If you have any cardiac issues, please list: _____

_____

If diabetic, when was the last time your Hemoglobin A1C was checked? _____

What was the Level? _____

5. **Medications**: (Include over the counter medications and dietary supplements)

Name	Dose	Frequency	Last Taken

Have you taken any blood thinners in the last 10 days? ☐No ☐Yes

Which blood thinner did you take? _____

6. **Recent Opioid Use:**

☐None
☐Recent opioid use (within 30 days)
☐Chronic use of Provider-prescribed opioid medication

OVER⇒

7. Social History:

- Do you smoke? ☐Yes ☐No ☐Past
  How long ago did you stop? _____
- Do you drink alcohol? ☐Yes ☐No
  Number per week? _____
- Do you drink caffeinated beverages? ☐Yes ☐No
  How many Cups/Glasses per day? _____
- Do you exercise regularly? ☐Yes ☐No
  Type? _____
  Amount? ☐ Sporadic (Once a month)
  ☐ Moderate (Once a week)
  ☐ Intense (Greater than once a week)

8. Previous operations:

Type	Year	Reason/Complications

9. Family History:

	IF LIVING		IF DECEASED	
	Age	**Health**	**Age at Death**	**Cause of Death**
MOTHER				
FATHER				

10. Employment:

Are you employed? ☐Yes ☐No ☐Retired

What is/was your occupation? _____

If Employed:

☐Desk-Based Labor ☐Moderate Physical Labor ☐Very Heavy Physical Labor
☐Light Physical Labor ☐Heavy Physical Labor

Functional Status:

☐ Independent ☐Partially Dependent ☐Totally Dependent

Signature: _____ Date: _____