NEWLAND MEDICAL
ASSOCIATES, P.C.

PATIENT HEALTH HISTORY

NAME:_____ BIRTHDAY:_____
PHYSICIAN:_____

HAVE YOU OR ANY FAMILY MEMBERS EVER BEEN DIAGNOISED WITH ANY OF THE FOLLOWING CONDITIONS?

DIABETES MELLITUS	YES	NO	WHO:_____
HIGH BLOOD PRESSURE	YES	NO	WHO:_____
MUSCULAR DYSTROPHY	YES	NO	WHO:_____
MULTIPLE SCLEROSIS	YES	NO	WHO:_____

HAVE YOU BEEN DIAGNOSED WITH ANY OF THE FOLLOWING CONDITIONS?

ARTHRITIS	YES	NO	WHO:_____
ASTHMA	YES	NO	WHO:_____
BLEEDING DISORDERS	YES	NO	WHO:_____
CANCER	YES	NO	WHO:_____
CHRONIC COUGH	YES	NO	WHO:_____
CHRONIC FATIGUE	YES	NO	WHO:_____
CHRONIC LUNG DISEASE	YES	NO	WHO:_____
CHRONIC PAIN	YES	NO	WHO:_____
DEPRESSION	YES	NO	WHO:_____
EMPHYSEMA	YES	NO	WHO:_____
FRACTURES	YES	NO	WHO:_____
GALL/KIDNEY STONES	YES	NO	WHO:_____
GLAUCOMA	YES	NO	WHO:_____
HAY FEVER	YES	NO	WHO:_____
HEART DISEASE	YES	NO	WHO:_____
HEPATITIS	YES	NO	WHO:_____
HIV/AIDS	YES	NO	WHO:_____
PARALYSIS	YES	NO	WHO:_____
SEIZURE DISORDER	YES	NO	WHO:_____
STROKE	YES	NO	WHO:_____
TUBERCULOSIS	YES	NO	WHO:_____

DO YOU HAVE ANY DRUG OR FOOD ALLERGIES?

_____

_____

PLEASE SIGN:_____ Date:_____