

# NEW PATIENT HEALTH HISTORY FORM

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

<b>Name</b> (Last, First, M.I.):		<input type="checkbox"/> M. <input type="checkbox"/> F.	<b>DOB:</b>
<b>Marital status:</b> <input type="checkbox"/> Single <input type="checkbox"/> Partnered <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed			
<b>Contact Phone:</b>			
<b>Address:</b>			
<b>Email:</b>			
<b>Previous or referring doctor:</b>		<b>Date of last physical exam:</b>	

## Notice of Patient Privacy/Patient Consent Form

I understand that as part of my healthcare, the physicians of One to One Health originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment and any plans for future care or treatment. I understand that this information is utilized to plan my care and treatment, to bill for services provided to me, to communicate with other healthcare providers and other routine healthcare operations such as assessing quality and reviewing competence of healthcare professionals.

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\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

## PERSONAL HEALTH HISTORY

**Childhood illness:** ☐ Measles ☐ Mumps ☐ Rubella ☐ Chickenpox ☐ Rheumatic Fever ☐ Polio

**Immunizations and dates:**

☐ Tetanus

☐ Pneumonia

☐ Hepatitis

☐ Chickenpox

☐ Influenza

☐ MMR (Measles, Mumps, Rubella)

**List any medical problems that other doctors have diagnosed**

## Surgeries

Year	Reason	Hospital

# Sample Medical History Write Up

**Stuart Porter**



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