PALO PINTO GENERAL HOSPITAL
400 SW 25th AVENUE
MINERAL WELLS, TX 76067
(940) 325-7891

New Patient History Form

Name: ______________________ Date: ______________

Email: ______________________________________

Answers on this form will help your health care provider better understand your medical concerns and conditions. If you cannot remember specific details, please provide your best guess.

Personal Medical History:

Please indicate whether you have had any of the following medical problems:

YES	NO	
☐	☐	Coronary Artery Disease/ Heart Disease
☐	☐	History of Heart Attack
☐	☐	High Blood Pressure
☐	☐	High Cholesterol
☐	☐	Diabetes
☐	☐	Thyroid Problem
☐	☐	Gout
☐	☐	Asthma
☐	☐	Kidney Disease
☐	☐	Kidney Stones
☐	☐	Stroke
☐	☐	Multiple Sclerosis

YES	NO	
☐	☐	Parkinson's Disease
☐	☐	Alzheimer's
☐	☐	Gastroesophageal Reflux Disease (GERD)
☐	☐	Crohn's Disease
☐	☐	Irritable Bowel Syndrome
☐	☐	Cancer Type: ______________
☐	☐	Back Injury Type of Injury: ______________
☐	☐	Glaucoma If **YES**, please check:

YES	NO	
☐	☐	Narrow Angle
☐	☐	Wide Angle

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Surgical History: Please list type of surgery and date of surgery.

____

____

Medications: Please list the medications you are currently taking including dosage and directions. Please include any blood thinners including aspirin, Coumadin/Warfarin, Plavix/ clopidogrel.

____

____

Pharmacy Name: ____________________ Location: ____________________

Allergies: Please list any allergies you may have and your reaction to it.

Allergy:	Reaction:
______________	______________
______________	______________
______________	______________

YES	NO		
☐	☐	Allergy to Latex:	Reaction: ______________
☐	☐	Allergy to Radiographic contrast/Iodine	Reaction: ______________

Family History: Please indicate yes or no, if your grandparents, parents, or brothers/sisters have had the following conditions:

YES	NO		YES	NO	
☐	☐	Kidney Stones	☐	☐	Prostate Cancer
☐	☐	Kidney Disease	☐	☐	Cancer

Social History:

	YES	NO	
Do you use any recreational drugs?	☐	☐	
Do you drink alcohol?	☐	☐	If yes, drinks per day? _______
Do you currently use tobacco?	☐	☐	

If **yes**, please circle the following:

Current every day smoker   Current some day smoker   Former smoker   Never smoked

Uses chewing tobacco   Uses snuff   Recently quit tobacco use