

Capital Healthcare Associates

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New Patient History

Name:	Date of Birth:		Date:
Please be as accurate as you can. Ap	proximate dates or years. If you don't know		
Drug		se (Strength)	Frequency (How Often)
		,	
MEDICA	AL PROBLEMS THAT YOU	HAVE NOW	
MEDICAL PROBLE	MS OR INJURIES THAT Y	OU HAD IN TH	E PAST
What Problem?			Approximately When?
Substance or Medication	ALLERGIES	(What Happens)	
Substance of Medication	Neaction	(what happens)	

Name:	Da ⁻	te of Birth:	Date:	
	SURGER	IES (Operations)		
What Operation?			Approximately When?	
		NATION CONTINUES AND ADMINISTRATION OF THE PROPERTY OF THE PRO		
	FAM	ILY HISTORY		
		List Health Proble	ems	
Nother				
ather				
isters (How many?)			
rothers (How many?)	3. M. J		
hildren (How Many?)			
Naternal Grandmother				
laternal Grandfather				
aternal Grandmother				
aternal Grandfather		<u> </u>		
	SOCI	AL HISTORY		
Tobacco Use?	Y / N	What Type?		
ow long?		When did you last u	se?	
Alcohol Use?	Y / N	What type?		
ow much?		How Often?		
Exercise?	Y / N	What type?		
ow long?		How Often?		
ave you used any drugs	s not prescribed by a physician?	Y / N		
If yes - What type?				
/ho else lives in your ho	ousehold?			
	OC	CUPATION		
What do you do now? How long have you do			done it?	
Vhat have you done the longest?		How long did you do	How long did you do it?	
INANAI INII:	ZATIONS (Check any immunizat	lone you had and this that	nnrovimate datas if bacium)	
Influenza	Pneumovax	Zostavax	Tetanus	
Hepatitis A	Hepatitis B	MMR	Gardisil	
Polio	Meningococcus	Hemophilus	Other	
1.010	Interningococcus			
Patient Signature			Date	
, attent dignature			Date	
Provider Signature			Date	