

OptimalLife Primary Care

New Patient Medical History

Complete as accurately as possible; attach additional pages if needed

Patient name: _____	Date of birth: _____
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Reason for establishing care

Primary concern/goals: _____
Previous primary care clinician/practice: _____

Current medications

Include prescriptions, over-the-counter medicines, vitamins, and supplements.

Medication Strength How taken Reason
1. _____
2. _____
3. _____
4. _____
5. _____

Allergies and adverse reactions

Medication/substance Reaction Severity
1. _____
2. _____
☐ No known medication allergies

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Page 2 - health conditions and procedures

Medical conditions

Check current or past conditions and add details.

☐ High blood pressure ☐ High cholesterol ☐ Diabetes/prediabetes ☐ Heart disease/heart failure ☐ Stroke/TIA ☐ Asthma/COPD ☐ Kidney disease ☐ Liver disease/hepatitis ☐ Thyroid disorder ☐ Cancer ☐ Blood/clotting disorder ☐ Arthritis/chronic pain ☐ Depression/anxiety ☐ Other mental health condition ☐ Seizure disorder ☐ Sleep apnea ☐ Gastrointestinal disorder ☐ Other

Details, dates, and treating clinicians: _____

Surgeries, procedures, and hospitalizations

Procedure/hospitalization | Approximate date | Facility/reason

1.
_____2.
_____3.

Family history

☐ Heart disease ☐ Stroke ☐ High blood pressure ☐ Diabetes ☐ Cancer ☐ Blood clots ☐ Kidney disease ☐ Mental health condition ☐ Other

Relative and condition: _____

Relative and condition: _____

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Page 3 - health habits and preventive care

Tobacco, alcohol, and other substances

Tobacco/nicotine: ☐ Never ☐ Former ☐ Current Type/amount: _____ Years: _____Alcohol: ☐ None ☐ Occasionally ☐ Weekly ☐ Daily Typical amount: _____Cannabis or other substances: ☐ No ☐ Yes - describe: _____

Health and safety

Exercise: _____ Diet concerns: _____ Sleep: _____
hours/night☐ Feels safe at home ☐ Safety concern ☐ Fall in past year ☐ Uses cane/walker ☐ Difficulty with daily activitiesHousing, food, transportation, or medication-cost concerns: ☐ No ☐ Yes - describe: _____

Preventive care

Last physical: _____	Last dental visit: _____	Last eye exam: _____
Last colon screening: _____	Last mammogram: _____	Last cervical screening: _____

Vaccinations known: ☐ Influenza ☐ COVID-19 ☐ Tdap ☐ Shingles ☐ Pneumococcal ☐ Hepatitis B ☐ Other

Reproductive/sexual health, when relevant

Pregnancy possibility/current pregnancy: ☐ No ☐ Yes ☐ Unsure Last menstrual period: _____

Contraception or fertility concerns: _____

Sexual health concerns or STI screening requested: _____

Patient attestation

I certify that the information provided is complete and accurate to the best of my knowledge. I will notify the practice of material changes.

Patient/authorized representative signature: _____	Date: _____
Printed name: _____ _____	Relationship: _____