



One West Lane, Suite B  
P.O. Box 1207  
Blue Hill, Maine 04614-1207

Phone 207-374-5007  
Fax 207-374-5099

[www.CoastalFamilyMedicineofMaine.com](http://www.CoastalFamilyMedicineofMaine.com)

**NEW PATIENT HEALTH HISTORY FORM 03/09**

To help expedite your appointment and ensure that we do not overlook important information concerning your medical history, please fill out the following information below. We will only ask that you fill out this information during your first visit. The information will then be entered into our computerized medical records and this document will be destroyed.

**Name:** \_\_\_\_\_

**Allergies:** (please list all allergies, including: medications, foods, environmental agents, etc. If there are none, please write NONE.)

\_\_\_\_\_  
\_\_\_\_\_

**Medications:** (please list all medications, herbals, supplements, or other product(s) taken on a daily basis for medicinal purposes. Make your best guess if name or dose is uncertain. If there are none, please write NONE.)

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\_\_\_\_\_

**Medical Conditions:** (please list all active medical conditions and significant past medical conditions, i.e. cancers, major illnesses, etc. If there are none, please write NONE.)

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\_\_\_\_\_

**Hospitalizations and Surgeries:** (please list all surgical procedures and approximate date or age at which you underwent the procedures- feel free to use lay terms/descriptions if you do not remember the medical name for the procedure. If there are none, please write NONE.)

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