

**New Horizon Family Health Services, Inc.**  
**Medical History Form – Part I**  
**(New Patients and Patients with charts located at another NHFHS office)**

**Patient Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**SSN:** \_\_\_\_\_

**Telephone Number (H):** \_\_\_\_\_ **(W):** \_\_\_\_\_ **(C):** \_\_\_\_\_

I, \_\_\_\_\_ understand that due to my request to be seen at a NHFHS Medical Office as a: **(circle one)**

- **new patient** I will be asked to provide my medical history  
or

- **as a patient usually seen and treated at another NHFHS location .** \_\_\_\_\_

**Location Last Seen**

My medical record is not available for my visit today and the practitioner seeing me does not have access to all of my medical information and may not be aware of all that my chart contains.

To facilitate my medical treatment today, I agree to be seen without my complete medical history and will provide thorough and accurate information to the practitioner seeing me. \_\_\_\_\_

**Patient's Initials**

I understand that if I wish to transfer my records, I must sign a release of medical records for my complete medical chart to be permanently transferred to:

Downtown 8 AM – 7 PM M-Th, 8 AM – 5 PM Friday

Greer 8 AM – 5 PM M – F

Travelers Rest 8 AM – 5 PM M – F

West End 8 AM – 5 PM M – F

Northwest Crescent 8 AM – 5 PM Monday, 8 AM – 12 N Tuesday

Golden Strip 8 AM – 5 PM Wednesday and Friday

\_\_\_\_\_  
(Other Requested Office)

\_\_\_\_\_  
**Signature of Patient/ Guardian**

Allergies: \_\_\_\_\_

Please list your current medications:

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

Have you had any of the following?

	Yes	No		Yes	No
Asthma or Other Lung Problems			Seizures / Epilepsy		
High Blood Pressure			Depression or Other Nervous Disorder		
Heart Problems or Stroke			Diabetes Type: _____		
Ulcers or Other Digestive Problems			Thyroid Problems		
Cancer Type: _____			HIV or Other Contagious Diseases		
Kidney Disease			Alcohol or Drug Problems		

Please list any surgeries you have had:

\_\_\_\_\_ Year: \_\_\_\_\_ Year: \_\_\_\_\_  
 \_\_\_\_\_ Year: \_\_\_\_\_ Year: \_\_\_\_\_

Have you been treated in the Hospital or Emergency Room in the last 6 months? Yes \_\_\_\_\_ No \_\_\_\_\_

When? \_\_\_\_\_ Where? \_\_\_\_\_ Why? \_\_\_\_\_