New Patient Information Form

Name:____ Age:_________ Date:______________

What is the reason for your visit?____

Health History:

Check those conditions that you have or have had in the past.

__Alcoholism	__Diabetes	__ High Cholesterol	__Prostates Problem
__Anemia	__Emphysema	__HIV	__Psychiatric Care
__Asthma	__Foot Ulcers	__Hysterectomy	__Rheumatic Fever
__Breast Lump	__Fractures	__Kidney Disease	__Seizures
__Bleeding Disorder	__Gallstones	__Kidney Stones	__Stomach Ulcers
__Cancer (Type_________)	__Glaucoma	__Liver Disease	__ Stroke
__Cataracts	__Gout	__Lupus	__Thyroid Problems
__Chemical Dependency	__Heart Disease	__Miscarriage(s)_____	__Tuberculosis
__Colitis	__Hepatitis	__Pacemaker	__Urinary Tract Infection, Frequently
__Depression	__ High Blood Pressure	__Polio	

Surgeries or Hospitalizations:

Year	Type of surgery/ Reason for hospitalization	Complications (if any)
______	____	______________________________
______	____	______________________________
______	____	______________________________
______	____	______________________________
______	____	______________________________

Social History:

Occupation:______________________________

Marital Status: Single___ Married___ Separated___ Divorced___ Widowed___

Use of Alcohol: Never___ Rarely___ Moderate___ Daily___

Smoking: Never___ Previously, but quit___ (when)___ Current___ packs/day___

Chewing Tobacco: Never___ Previously, but quit___ (when)___ Current___

Use of Drugs: Never___ Previously, but quit___ (when)___ Current___ type/frequency______________

Caffeine Intake: Type_____________________________________ Cups per day_________

Family History:

	Age	If Deceased, cause of death		Age	If Deceased, cause of death
Father	___	_________________________	Mother	___	_________________________
Brothers	___	_________________________	Sisters	___	_________________________
	___	_________________________		___	_________________________
	___	_________________________		___	_________________________
Children	___	_________________________	Other	___	_________________________
	___	_________________________		___	_________________________

Has a blood relative ever had any of the following condition?

	Relationship to you		Relationship to you
Diabetes	______________________________	Stroke	______________________________
High Blood Pressure	______________________________	Thyroid Disease	______________________________
High Cholesterol	______________________________	Osteoporosis	______________________________
Heart Disease	______________________________	Cancer (type)	______________________________
			______________________________

Medications: List Prescription and over the counter medications, vitamins, and supplements you are currently taking.

Medication Name	**Dose**	**Frequency**

Medication Allergies: ____

Please provide the last date (if applicable) of your:

Vaccines-

Tetanus__________________

Pneumococcal_____________

Flu ______________________

Shingles__________________

Preventative Medicine-

Colonoscopy______________________

Bone Density Scan_________________

Mammogram______________________

PAP Smear________________________

Check symptoms you have currently or have had within the last year.

Women ONLY:

General

__ Chills
__ Fatigue
__Fever
__Malaise
__ Night Sweats
__Weight Gain
__ Weight Loss
__ Other:______________

HEENT

__ Ear Drainage
__Ear Pain
__Eye Discharge
__Eye Pain
__Hearing Loss
__Nasal Drainage
__Sinus Pressure
__Sore Throat
__Visual Changes
__Other:_______________

Respiratory

__ Chronic Cough
__ Cough
__ Known TB exposure
__Shortness of Breath
__ Wheezing
__ Other:______________

Cardiovascular

__Chest Pain
__Claudication (Lower extremity cramping with exercise)
__Swelling
__Palpitations (Heart Pounding)
__Other:_______________

Gastrointestinal

__Abdominal Pain
__Blood in stools
__Change in stools
__Constipation
__Diarrhea
__Heartburn
__Loss of Appetite
__Nausea
__Vomiting
__Other:_______________

Genitourinary

__ Painful Urination
__Blood in Urine
__Large volumes of urine
__ Urinary Frequency
__ Urinary incontinence
__ Urinary retention
__Other:_______________

Reproductive

__Abnormal Pap
__ Painful Periods
__Painful Intercourse
__ Hot Flashes
__Irregular Periods
__Vaginal Discharge
__Other:_______________

Integumentary

__Breast Discharge
__Breast Lump
__Brittle hair
__Brittle Nails
__Hair Loss
__Abnormal Hair Growth
__Hives
__Itching
__Mole Changes
__Rash
__Skin Lesion
__Other:_______________

Neurological

__ Dizziness
__Arm/Leg Numbness
__Arm/Leg Weakness
__Walking Disturbance
__ Headache
__Memory Loss
__Seizures
__Tremors
__Other:_______________

Psychiatric

__ Anxiety
__ Depression
__Insomnia
__Other:_______________

Metabolic/Endocine

__ Cold intolerance
__Heat intolerance
__Abnormally Excessive Thirst
__ Abnormally Excessive Hunger
__Other:_______________

Musckuloskeletal

__ Back Pain
__Joint Pain
__Joint Swelling
__Muscle Weakness
__Neck Pain
__Other:_______________

Hematologic/Lymphatic

__Easy Bleeding
__Easy Bruising
__Swollen Lymph Nodes
__Other:_______________

Immunologic

__ Contact Allergy
__Environmental Allergies
__Food Allergies
__Seasonal Allergies
__Other:_______________

Check symptoms you have currently or have had within the last year.

Men ONLY:

General

__ Chills
__ Fatigue
__Fever
__Malaise
__ Night Sweats
__Weight Gain
__ Weight Loss
__ Other:______________

HEENT

__ Ear Drainage
__Ear Pain
__Eye Discharge
__Eye Pain
__Hearing Loss
__Nasal Drainage
__Sinus Pressure
__Sore Throat
__Visual Changes
__Other:_______________

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__Abdominal Pain
__Blood in stools
__Change in stools
__Constipation
__Diarrhea
__Heartburn
__Loss of Appetite
__Nausea
__Vomiting
__Other:_______________

Genitourinary

__ Dribbling
__ Painful Urination
__Blood in Urine
__Large volumes of urine
__ Slow Stream
__ Urinary Frequency
__ Urinary incontinence
__ Urinary retention
__Other:_______________

Reproductive

__Erection Difficulties
__Penile Discharge
__Sexual Disfunction
__Other:_______________

Metabolic/Endocine

__ Cold intolerance
__Heat intolerance
__Abnormally Excessive Thirst
__ Abnormally Excessive Hunger
__Other:_______________

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__ Dizziness
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