NEW PATIENT

NAME:
MRN:

Today's Date:____________________
Primary Physician:________________
PT. DOB______________________
PHONE:______________________

Please completely fill out this form

Reason for Today's Visit:

Past Surgeries and Serious Injuries:	Year	**Serious Illnesses and Hospitalizations**	Year
__________	19__	__________	19__
__________	19__	__________	19__
__________	19__	__________	19__
__________	20__	__________	20__

Past Medical History: (Circle- personal medical history) — If yes how long/ please provide details:

- High blood pressure, Heart attack, Heart Disease, Stroke, Blood Clots, Blocked Arteries, Rheumatic Fever
- Asthma, Tuberculosis or positive TB skin test, Emphysema, Pneumonia, Seasonal Allergies
- Gallstones, Hepatitis, Ulcers, Colon polyps, Diverticulitis, Spastic Colon, Irritable Bowel Syndrome
- Frequent urinary infections, Kidney stones, other Kidney disease, Prostate problems
- Diabetes, High Cholesterol, High Triglycerides, Thyroid Disorder
- Osteoporosis, Arthritis, Gout
- Anemia, Other Blood Disorder, or Cancer:____________

  Have you ever had a blood transfusion?__________ If yes, when?______
- Migraine, Depression, Anxiety, Glaucoma
- Other, Please Describe:____________________
- Do you see any other physicians on a regular basis? Yes/No
  Who:________________ For:____________

Periodic Health Screening: *When was your Last:*

Mammography:______ Pap Smear______ Colon Exam:______
B/P Exam:______ Flu Vaccine:______ Tetanus Vaccine:______
Pneumonia Vaccine:______ Bone Densitometry:______ Prostate Exam______
Other:________________________

Family Medical History

	Living	Deceased	Age		Number Living	Deceased
Mother	☐	☐	______	Brothers:	______	______
Father	☐	☐	______	Sisters:	______	______

Have any of your family had any of the following diseases? Relationship

High blood pressure/ Stroke/ Diabetes: ______________ ______________

Heart Attack/ Other Heart Disease: ______________ ______________

Cancer, Type: ______________ ______________

Hereditary or Genetic Disorders: ______________ ______________

Lifestyle and Social History: (Please circle those that apply to you or fill in the blanks)

Marital Status: Single/ Married: (# of Times)______ How Long______ # of Children______
Divorced/ Separated/ Widowed Who do you live with?______
Last Grade Completed:______ Jr High High School College Post-Grad
Current Occupation:______ How many hours per week?______
Diet/ Special Diet:______ Exercise (Type & Frequency):______
Hobbies and Interests:______
Caffeine? Yes/ No How many cups per day?______
Do you use tobacco products? Yes/ No Type:______ For how long:______
How much:______ If you quit, when?______ Are you interested in quitting?______
Alcohol Intake: None Occasional 1-2 drinks per day More than 2 drinks per day
Drugs: None Rarely Occasional Daily Type:______ Quit______
Do you feel your life is stressful? Yes No Source of stress:______
How many hours do you sleep per night?______ Do you wear seatbelts, % of time:______

Medications Please list all prescription drugs you are currently taking:

Drug	Strength	Frequency	Drug	Strength	Frequency
1.			6.		
2.			7.		
3.			8.		
4.			9.		
5.			10.		

Please list all over the counter medications you take:______

______

Do you have any drug allergies?______

List drug and type of reaction: ______

REVIEW OF SYSTEMS: In general, how do you feel?________________ How is your energy level?
________ Has your weight fluctuated more than 10 pounds in the past year?________ By how much?________

Have you had any fevers, chills or night sweats?________________

HEENT: Any significant changes in vision?________________ Hearing?________

Any pollen allergies or bad nasal drainage?________________ Other:________

RESPIRATORY: Any chronic cough, chest congestion or shortness of breath?________

Any coughing up of blood?________ Other:________________

CARDIOVASCULAR: Any chest pain, pressure or tightness?________________

If so, what brings it on?________ Any heart palpitations or irregular heart beat?________

Any edema or swelling?________ Any leg cramps with walking?________

GI: Any chronic or severe indigestion?________ Any pain or difficulty swallowing?________

Any nausea or vomiting?________ Any change in bowel habits, diarrhea or constipation?________
________________ Any blood in your stool?________________

GU: Any burning with urination?________ Any difficulty urinating?________________

Any blood in your urine?________ Increased frequency of urination?________

Frequency of nighttime urination:________ Leakage of urine?________________

MEN: Do you do monthly self-testicular exams?________ Any lumps or pain noted?________

Any impotence or sexual dysfunction?________________ Medical treatment desired?________

WOMEN: Do you perform monthly self-breast exams?________ Any breast pain, discharge or lumps?________

Are menstrual periods regular?________ Date of last period:________________

Any vaginal discharge, discomfort or unexpected bleeding?________ Any pain with intercourse?________

Method of contraception:________ Date of menopause or hysterectomy:________

Any impotence or sexual dysfunction?________ Other:________________

MUSCULOSKELETAL: Any chronic or bothersome arthritis or joint pain?________ If so, which joints?
________ Any chronic or severe back pain?________________

Any unusual muscle aches or cramping?________________

SKIN: Any skin lesions that are growing, changing or needing attention?________ What area?________

SLEEP: Are you sleeping well?________________ Number of hours per night:________

PSYCHOLOGIC: Is stress level high, low or average?________ Any feelings of anxiety, depression or nervousness?________________

NEUROLOGIC: Any chronic or unusual headaches?________________ Any numbness or tingling?________ Any lightheadedness, dizziness or fainting spells?________

OTHER: