

New Patient History

Name: _____ Date of Birth: _____ Current Age: _____ Today's Date: _____

Referring Physician: _____ Primary Care Provider: _____

Reason for Today's Appointment: _____

Past Medical History:

<input type="checkbox"/> Stroke or TIA	<input type="checkbox"/> Concussion	<input type="checkbox"/> History of cancer: _____
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Migraine	<input type="checkbox"/> Kidney disease
<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Anxiety	<input type="checkbox"/> Bleeding disorder
<input type="checkbox"/> High cholesterol	<input type="checkbox"/> Depression	<input type="checkbox"/> Reflux
<input type="checkbox"/> Heart disease	<input type="checkbox"/> Hypothyroidism	<input type="checkbox"/> Ulcers
<input type="checkbox"/> Peripheral vascular disease	<input type="checkbox"/> Lung disease	<input type="checkbox"/> Arthritis
<input type="checkbox"/> Seizures	<input type="checkbox"/> Sleep apnea: Do you use CPAP? No / Yes	<input type="checkbox"/> Cataracts
		<i>For Women: Are you pregnant? N / Y</i>

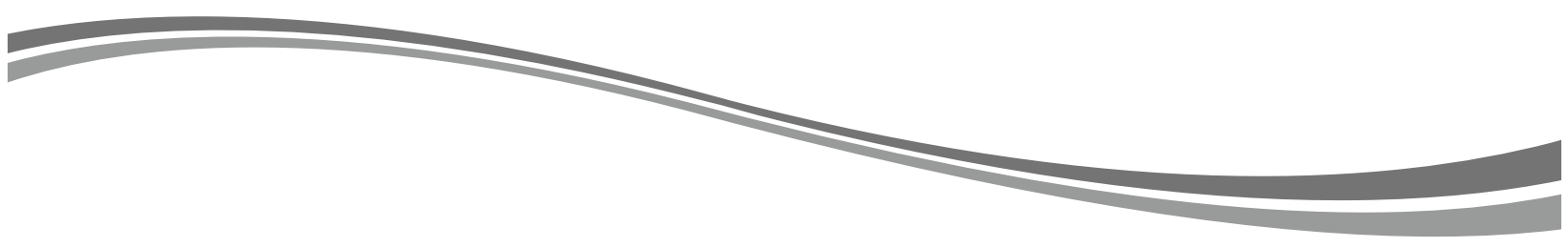
Other Conditions: _____

Prior Surgeries and Dates: _____

Medication Allergies: _____

Medications: (Include all prescriptions and over-the-counter medications, including vitamins, supplements, and herbs)

Name	Dosage	Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____



New Patient History (Continued)

Patient Name: _____

Symptoms:

- | | | |
|--|---|---|
| <input type="checkbox"/> Recent weight loss; Amount: _____ | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Burning with urination |
| <input type="checkbox"/> Recent weight gain; Amount: _____ | <input type="checkbox"/> Swelling of feet or ankles | <input type="checkbox"/> Excessive thirst |
| <input type="checkbox"/> Fever | <input type="checkbox"/> Fainting | <input type="checkbox"/> Unusual appetite |
| <input type="checkbox"/> Night sweats | <input type="checkbox"/> Frequent cough | <input type="checkbox"/> Frequent urination |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Snoring/gasping for air at night | <input type="checkbox"/> Rashes |
| <input type="checkbox"/> Blurred vision | <input type="checkbox"/> Trouble breathing | <input type="checkbox"/> Recent change in wart or mole |
| <input type="checkbox"/> Double vision | <input type="checkbox"/> Coughing up blood | <input type="checkbox"/> Easy bleeding or bruising |
| <input type="checkbox"/> Blindness | <input type="checkbox"/> Productive cough | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Hearing loss | <input type="checkbox"/> Nausea | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Ringing in ears | <input type="checkbox"/> Frequent indigestion | <input type="checkbox"/> Difficulty falling asleep |
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> Black, tarry, or bloody stools | <input type="checkbox"/> Early morning awakenings |
| <input type="checkbox"/> Palpitations | <input type="checkbox"/> Difficulty urinating | <input type="checkbox"/> Feeling persistently sad or blue |
| | <input type="checkbox"/> Incontinence | <input type="checkbox"/> Loss of ability to enjoy life |

Is today's visit related to an injury? No / Yes – Date: _____

Family History:

Father: Alive / Deceased, Medical Conditions: _____

Mother: Alive / Deceased, Medical Conditions: _____

Siblings: # of Brothers _____ # of Sisters _____ Medical Conditions: _____

Children: # of Sons: _____ # of Daughters: _____ Medical Conditions: _____

Does anyone in your family have symptoms similar to yours? _____

Are any medical conditions prominent in your family? _____

Social History:

Birth Place: _____ Education: _____ Occupation: _____

Marital Status: _____ Who lives with you?: _____

Smoking: No / Yes – Packs per day: _____ Number of Years Smoked: _____ Quit Date: _____

Alcohol: No / Yes – Amount per week: _____ Have you recently tried to cut down?: No / Yes

Marijuana: No / Yes – Frequency: _____ Other Drugs: No / Yes – Which: _____

Number of caffeinated beverages per day (e.g. coffee, soda, tea): _____

Name and relation of others with you today: _____

