

NEW PATIENT HISTORY FORM

NAME (Last, First, Middle)			AGE	BIRTHDATE	SEX
HOME PHONE	WORK PHONE	OCCUPATION		MARITAL STATUS <input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> W <input type="checkbox"/> D	
EMERGENCY CONTACT		CONTACT'S PHONE		IF MARRIED, SPOUSE'S NAME	
PREVIOUS PHYSICIAN			CURRENT PHYSICIAN		
WHICH <u>LOCAL</u> PHARMACY DO YOU USE?					
HOW DID YOU HEAR ABOUT OUR PRACTICE?					

ALLERGIES TO MEDICATIONS, X-RAY DYES, OR OTHER SUBSTANCES: NO YES
 (If yes, please list name of medicine and type of reaction)

PAST MEDICAL HISTORY AND REVIEW OF SYSTEMS

(Please check off if you have had any problems with or are presently experiencing any of the following)

- | | | | | |
|-----------------------------------------------------|-----------------------------------------------|-------------------------------------------------------|-------------------------------------------------|------------------------------------------------------------|
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Asthma | <input type="checkbox"/> Constipation | <input type="checkbox"/> Thyroid disease | <input type="checkbox"/> Blood disorders |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Head or neck radiation | <input type="checkbox"/> Venereal diseases |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Blood in stool | <input type="checkbox"/> Headache | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Chest pain/chest tightness | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> TB | <input type="checkbox"/> Change in bowel habits | <input type="checkbox"/> Kidney stones | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Swollen ankles | <input type="checkbox"/> Persistent cough | <input type="checkbox"/> Unexplained weight gain/loss | <input type="checkbox"/> Difficulty urinating | <input type="checkbox"/> Alcohol abuse |
| <input type="checkbox"/> Palpitations | <input type="checkbox"/> Abdominal discomfort | <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Drug abuse |
| <input type="checkbox"/> Lightheadedness | <input type="checkbox"/> Indigestion | <input type="checkbox"/> Gall Bladder disease | <input type="checkbox"/> Low back problems | <input type="checkbox"/> Impotence or Erectile Dysfunction |
| <input type="checkbox"/> Frequent urination | <input type="checkbox"/> Nausea | <input type="checkbox"/> Colitis | <input type="checkbox"/> Gout | <input type="checkbox"/> Other (list below) |
| <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Vomiting | <input type="checkbox"/> Hepatitis or jaundice | <input type="checkbox"/> Skin diseases | |

WOMEN ONLY:

Menstrual Periods

Age onset: _____ Periods regular or irregular: _____ Still having periods: Yes No

Date of last period: _____ Difficulty with periods: _____

Pregnancies: _____ Births: _____ Miscarriages: _____ Abortions: _____

Leakage of Urine: No Yes (Please describe) _____

Pelvic pain: No Yes (Please describe) _____

Abnormal discharge No Yes (Please describe) _____

History of abnormal Pap Smear No Yes (Please describe) _____

Review Date: _____

OPERATIONS AND THEIR DATES:

Tonsillectomy _____ Appendectomy _____ Hysterectomy _____ Hernia Repair _____
 Gallbladder _____ Other (please list) _____

HOSPITALIZATIONS (Other than surgical and childbirth)

ACCIDENTS

FAMILY HISTORY

MOTHER

FATHER

SIBLINGS

Cancer (describe type)	_____	_____	_____
Hypertension (high blood pressure)	_____	_____	_____
Heart Disease	_____	_____	_____
Diabetes	_____	_____	_____
Strokes	_____	_____	_____
Mental disease (anxiety, depression etc.)	_____	_____	_____
Drug or alcohol addiction	_____	_____	_____
Glaucoma	_____	_____	_____
Bleeding diseases	_____	_____	_____
Other _____	_____	_____	_____

HABITS

<input type="checkbox"/> Smoking	Duration _____	Amount _____	Quit? When? _____
<input type="checkbox"/> Alcohol	Duration _____	Amount _____	Quit? When? _____
<input type="checkbox"/> Coffee/Caffeine	Duration _____	Amount _____	Quit? When? _____
<input type="checkbox"/> Drugs	Duration _____	Amount _____	Quit? When? _____

MEDICATIONS (Prescriptions, over-the-counter, vitamins, herbs, etc.)

DRUG NAME	DOSE	DRUG NAME	DOSE
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

TEST AND IMMUNIZATIONS

	Yes	Year Performed	Not Sure	Never	Comments
Pap Smear (Women)	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Breast Mammography	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Sigmoidoscopy	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Stool Occult Blood	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
EKG	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Tetanus (DT)	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Pneumovax	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____