New Patient History Form

PATIENT NAME____________________________________ DOB_________________________

Reason for today's visit:____

Allergies:____

Current Medications:

Medication Dose Frequency

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Do you take Blood Thinners, Plavix or Aspirin? _______________

Please circle any of the following that apply to your health history

Hypertension	Stroke	Seizures
Migraines	Anemia	Lung Cancer
Breast Cancer	Colon Cancer	Skin Cancer
Other Cancer	Hyperthyroid	Hypothyroid
Diabetes	Stomach or peptic ulcer	Kidney Disease
Hepatitis	AIDS/HIV	Sexually transmitted disease
Asthma	Tuberculosis	Pneumonia
Emphysema	Heart Abnormalities	Congestive Heart Failure
Heart Attack	Mitral Valve Disease	High Cholesterol

Patient Name____ DOB________________

Coronary Artery Disease	Heart Murmur	Heart Valve Disease
Heart Palpitations	Other Lung Disease	Hiatal Hernia/GERD
Gallstones	Pancreatitis	Colitis
Spastic Colon	Kidney Stones	Kidney Infections
Rheumatoid Arthritis	Osteoarthritis	Osteoporosis
Skin Disease	Phlebitis/blood clots	Anemia
Bleeding disorder	Depression	Anxiety
Hives/Eczema	Blood Transfusions	Bladder Infections
Hemorrhoids	Hernia	Back problems

Any other issues:____

Family History

Age if living   Age at death   Health Problems

Father____

Mother____

Brothers____

Sisters____

Children____

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Social History

Do you smoke? _________ If so, how much per day___________________

Do you drink alcohol? _____________ If so, how many drinks per day_____________________

Do you use recreational drugs?_______ If so, how often___________________

Previous Surgeries

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Patient____ **DOB**________________

Are you currently experiencing any of the following?

Constitution:

Fever Chills Weight loss Fatigue Sweating Weakness

Skin:

Skin Rash Itching

HENT:

Headaches Hearing Loss Congestion Sore Throat

Cardiovascular:

Chest Pain Palpitations Shortness of breath Claudication (calf pain with walking)

Leg swelling

Respiratory:

Cough Coughing up blood Sputum production Shortness of breath Wheezing

Gastrointestinal:

Heart Burn Nausea Vomiting Abdominal pain Diarrhea Constipation Blood in Stool

Black Sticky stools

Genitourinary:

Pain with urination Urgency with urination Frequency with urination Blood in urine Flank pain

Musculoskeletal:

Muscle pains Neck pain Back pain Joint Pain Falls

Endo/Hemo/Allergies:

Easy bruising or bleeding Environmental Allergies Excessive thirst

Neurological:

Dizziness Tingling Tremor Sensory changes Speech Changes Focal weakness Seizures

LOC (Passing out)

Psychiatric:

Depression Suicidal Ideas Substance abuse Hallucinations Nervousness Insomnia

Signature____