

## New Patient Information & History

Date \_\_\_\_\_

Sex:  Male  Female

First Name \_\_\_\_\_ Middle \_\_\_\_\_ Last Name \_\_\_\_\_

How would you like to be addressed?  First Name  Nickname \_\_\_\_\_  Other \_\_\_\_\_

Age \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_ Weight gain or loss within past year \_\_\_\_\_ lbs

**Previous Surgery** (Please list all surgeries and dates)

<u>Operation</u>	<u>Surgeon's Name</u>	<u>Year</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

<u>Serious Illnesses or Hospitalizations</u>	<u>Date</u>	<u>Chronic Medical Conditions</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

**Any relative with the following condition(s)?**

- Cancer...Type \_\_\_\_\_
- Diabetes
- Heart Disease
- High Blood Pressure
- Lung Disease
- Kidney Disease
- Blood/Bleeding Disorders
- Asthma
- Mental Disease
- Asthma
- HIV/AIDS

**Significant Family History**

- Mother \_\_\_\_\_
- Father \_\_\_\_\_
- Brother(s) \_\_\_\_\_
- Sister(s) \_\_\_\_\_

**Current Medications** (prescription, vitamins, supplements, etc.)

1. \_\_\_\_\_ 6. \_\_\_\_\_
2. \_\_\_\_\_ 7. \_\_\_\_\_
3. \_\_\_\_\_ 8. \_\_\_\_\_
4. \_\_\_\_\_ 9. \_\_\_\_\_
5. \_\_\_\_\_ 10. \_\_\_\_\_

Additional comments: \_\_\_\_\_

**Social History**

Do you smoke cigarettes      Yes    No     If yes, how many per day? \_\_\_\_\_

Do you consume alcohol?      Yes    No     If yes, how much and what type? \_\_\_\_\_

Do you have a history of street drug use    Yes    No     What type and frequency? \_\_\_\_\_

Have you ever had a blood transfusion      Yes    No     For what purpose? \_\_\_\_\_

**Allergies**

Do you have any drug allergies      Yes    No     If yes, please list and describe reaction \_\_\_\_\_

Do you have seasonal allergies?      Yes    No     If yes, please describe \_\_\_\_\_

**Review of Systems:** Are you experiencing any of the following?

<b>General</b> <input type="checkbox"/> None	<b>HEENT</b> <input type="checkbox"/> None
<input type="checkbox"/> Change in appetite?	<input type="checkbox"/> Frequent headaches?
<input type="checkbox"/> Recent weight loss or gain?	<input type="checkbox"/> Sore throat or difficulty swallowing?
<input type="checkbox"/> Fever, chills or sweats?	<input type="checkbox"/> Visual changes or double vision?
<input type="checkbox"/> Fatigue?	<input type="checkbox"/> Sensitivity to light?
<input type="checkbox"/> Chronic Pain?	<input type="checkbox"/> Hearing loss or ringing in the ears?
<input type="checkbox"/> Difficulty sleeping?	<input type="checkbox"/> Ear drainage or pain?
<input type="checkbox"/> History of depression or anxiety?	<input type="checkbox"/> Frequent or severe nosebleeds?
<b>Cardiovascular</b> <input type="checkbox"/> None	<b>Respiratory</b> <input type="checkbox"/> None
<input type="checkbox"/> Pain, tightness or pressure in chest?	<input type="checkbox"/> Shortness of breath?
<input type="checkbox"/> Palpitations or irregular heartbeats?	<input type="checkbox"/> Persistent cough or wheezing?
<input type="checkbox"/> Swelling in feet or hands?	<input type="checkbox"/> Coughing up blood?
<input type="checkbox"/> Cramps in legs?	<input type="checkbox"/> Difficulty breathing?
<b>Gastrointestinal</b> <input type="checkbox"/> None	<b>Musculoskeletal</b> <input type="checkbox"/> None
<input type="checkbox"/> Frequent indigestion or heartburn?	<input type="checkbox"/> Joint, bone or muscle pain?
<input type="checkbox"/> Nausea or vomiting?	<input type="checkbox"/> Muscle weakness?
<input type="checkbox"/> Bloody stools, diarrhea or constipation?	<input type="checkbox"/> Joint stiffness or swelling?
<b>Skin</b> <input type="checkbox"/> None	<b>Neurological</b> <input type="checkbox"/> None
<input type="checkbox"/> Rashes or redness?	<input type="checkbox"/> Dizziness or loss of consciousness?
<input type="checkbox"/> Itching or flaking?	<input type="checkbox"/> Convulsions or seizures?
<input type="checkbox"/> Non-healing areas or masses?	<input type="checkbox"/> Memory loss?
<input type="checkbox"/> Changes in color or size of moles?	<input type="checkbox"/> Severe headaches?
<b>Endocrine</b> <input type="checkbox"/> None	<b>Hematologic/Lymphatic</b> <input type="checkbox"/> None
<input type="checkbox"/> Heat or cold intolerance?	<input type="checkbox"/> Easy bruising?
<input type="checkbox"/> Excessive thirst or hunger?	<input type="checkbox"/> Frequent infections?
<input type="checkbox"/> Frequent urination?	<input type="checkbox"/> Swollen glands or lymph nodes?
<input type="checkbox"/> Other glandular problem?	<input type="checkbox"/> Chronic fatigue?
<b>Genitourinary</b> <input type="checkbox"/> None	<b>Women Only:</b>
<input type="checkbox"/> Burning or painful urination?	<input type="checkbox"/> Regular menstrual cycles
<input type="checkbox"/> Blood in urine?	# Pregnancies _____ # Deliveries _____
<input type="checkbox"/> Difficulty urinating?	<input type="checkbox"/> Menopause at age _____
<input type="checkbox"/> Difficulty holding urine?	