

New Patient Information & History

Date _____

Sex: Male Female

First Name _____ Middle Initial _____ 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>Year</u>	<u>Surgeon's Name</u>

Serious Illnesses or Hospitalizations *(Please include dates)*

Family History

	Age	State of Health	Has any relative had:	YES	NO
Mother _____			Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Father _____			Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Brother(s) _____			Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Sister(s) _____			Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>
Children _____			Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>
_____			High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
_____			Lung Disease	<input type="checkbox"/>	<input type="checkbox"/>
_____			Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>
<u>Please list all medications you are currently taking with dosages:</u>			Blood/Bleeding Disorders	<input type="checkbox"/>	<input type="checkbox"/>
_____			Asthma	<input type="checkbox"/>	<input type="checkbox"/>
_____			Mental Disease	<input type="checkbox"/>	<input type="checkbox"/>
_____			HIV/Aids	<input type="checkbox"/>	<input type="checkbox"/>

Please include prescription and over-the-counter medications (including vitamins, supplements, etc.)

Social History

	YES	NO	
Do you smoke cigarettes?	<input type="checkbox"/>	<input type="checkbox"/>	If yes, how many per day? _____
Do you consume alcohol?	<input type="checkbox"/>	<input type="checkbox"/>	If yes, how much & type of alcohol? _____
Do you have a history of street drug use?	<input type="checkbox"/>	<input type="checkbox"/>	If yes, type and frequency of use? _____
Have you ever had a blood transfusion?	<input type="checkbox"/>	<input type="checkbox"/>	If yes, purpose of transfusion? _____

Allergies

	YES	NO	
Do you have any food or drug allergies?	<input type="checkbox"/>	<input type="checkbox"/>	If yes, please list and describe reaction _____
Do you have any seasonal allergies?	<input type="checkbox"/>	<input type="checkbox"/>	If yes, please describe _____

Review of Systems: Have you had any of the following recently or chronically?

General	YES	NO	HEENT	YES	NO
Change in appetite?	<input type="checkbox"/>	<input type="checkbox"/>	Frequent headaches?	<input type="checkbox"/>	<input type="checkbox"/>
Recent weight loss or gain?	<input type="checkbox"/>	<input type="checkbox"/>	Loss of consciousness?	<input type="checkbox"/>	<input type="checkbox"/>
Fever, chills or sweats?	<input type="checkbox"/>	<input type="checkbox"/>	Visual changes or double vision?	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue?	<input type="checkbox"/>	<input type="checkbox"/>	Sensitivity to light?	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Pain?	<input type="checkbox"/>	<input type="checkbox"/>	Hearing loss or ringing in the ears?	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty sleeping?	<input type="checkbox"/>	<input type="checkbox"/>	Ear drainage or pain?	<input type="checkbox"/>	<input type="checkbox"/>
History of depression or anxiety?	<input type="checkbox"/>	<input type="checkbox"/>	Frequent or severe nosebleeds?	<input type="checkbox"/>	<input type="checkbox"/>
			Difficulty breathing?	<input type="checkbox"/>	<input type="checkbox"/>
			Sore throat or difficulty swallowing?	<input type="checkbox"/>	<input type="checkbox"/>
Cardiovascular	YES	NO	Respiratory	YES	NO
Pain, tightness or pressure in chest?	<input type="checkbox"/>	<input type="checkbox"/>	Shortness of breath?	<input type="checkbox"/>	<input type="checkbox"/>
Palpitations or irregular heartbeats?	<input type="checkbox"/>	<input type="checkbox"/>	Persistent cough or wheezing?	<input type="checkbox"/>	<input type="checkbox"/>
Swelling in feet or hands?	<input type="checkbox"/>	<input type="checkbox"/>	Coughing up blood?	<input type="checkbox"/>	<input type="checkbox"/>
Cramps in legs?	<input type="checkbox"/>	<input type="checkbox"/>			
Gastrointestinal	YES	NO	Musculoskeletal	YES	NO
Frequent indigestion or heartburn?	<input type="checkbox"/>	<input type="checkbox"/>	Joint, bone or muscle pain?	<input type="checkbox"/>	<input type="checkbox"/>
Nausea or vomiting?	<input type="checkbox"/>	<input type="checkbox"/>	Muscle weakness?	<input type="checkbox"/>	<input type="checkbox"/>
Bloody stools, diarrhea or constipation?	<input type="checkbox"/>	<input type="checkbox"/>	Joint stiffness or swelling?	<input type="checkbox"/>	<input type="checkbox"/>
Fluid intolerance?	<input type="checkbox"/>	<input type="checkbox"/>			
Skin	YES	NO	Neurological	YES	NO
Rashes or redness?	<input type="checkbox"/>	<input type="checkbox"/>	Dizziness or loss of consciousness?	<input type="checkbox"/>	<input type="checkbox"/>
Itching or flaking?	<input type="checkbox"/>	<input type="checkbox"/>	Convulsions or seizures?	<input type="checkbox"/>	<input type="checkbox"/>
Non-healing areas or masses?	<input type="checkbox"/>	<input type="checkbox"/>	Memory loss?	<input type="checkbox"/>	<input type="checkbox"/>
Changes in color or size of moles?	<input type="checkbox"/>	<input type="checkbox"/>	Severe headaches?	<input type="checkbox"/>	<input type="checkbox"/>
Endocrine	YES	NO	Hematologic/Lymphatic	YES	NO
Heat or cold intolerance?	<input type="checkbox"/>	<input type="checkbox"/>	Easy bruising?	<input type="checkbox"/>	<input type="checkbox"/>
Excessive thirst or hunger?	<input type="checkbox"/>	<input type="checkbox"/>	Frequent infections?	<input type="checkbox"/>	<input type="checkbox"/>
Frequent urination?	<input type="checkbox"/>	<input type="checkbox"/>	Swollen glands or lymph nodes?	<input type="checkbox"/>	<input type="checkbox"/>
Other glandular problem? (Please specify _____)	<input type="checkbox"/>	<input type="checkbox"/>	Chronic fatigue?	<input type="checkbox"/>	<input type="checkbox"/>
Genitourinary	YES	NO	Women Only:	YES	NO
Burning or painful urination?	<input type="checkbox"/>	<input type="checkbox"/>	Menstrual cycles (periods)?	<input type="checkbox"/>	<input type="checkbox"/>
Blood in urine?	<input type="checkbox"/>	<input type="checkbox"/>	If no, age at menopause _____		
Difficulty urinating?	<input type="checkbox"/>	<input type="checkbox"/>	Are your menstrual cycles regular?	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty holding urine?	<input type="checkbox"/>	<input type="checkbox"/>	Breast pain or lumps?	<input type="checkbox"/>	<input type="checkbox"/>
			Discharge from breasts?	<input type="checkbox"/>	<input type="checkbox"/>