New Patient Medical History Form

Patient Name ____ Today's Date ____________________

Age ____ Birth date ________ Date of last physical examination ________ Referring Physician _________________________

What is your reason for visit? ____

SYMPTOMS

Check (√) conditions your currently have or have had in the past year

GENERAL
- ☐ Chills
- ☐ Depression
- ☐ Dizziness
- ☐ Fainting
- ☐ Fever
- ☐ Forgetfulness
- ☐ Headache
- ☐ Loss of sleep
- ☐ Loss of weight
- ☐ Nervousness
- ☐ Numbness
- ☐ Sweats

MUSCLE/JOINT/BONE
Pain/ weakness/numbness in:
- ☐ Arms ☐ Hips
- ☐ Back ☐ Legs
- ☐ Feet ☐ Neck
- ☐ Hands ☐ Shoulders

GENITO-URINARY
- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Lack of bladder control
- ☐ Painful urination

GASTROINTESTINAL
- ☐ Appetite poor
- ☐ Bloating
- ☐ Bowel changes
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive hunger
- ☐ Excessive thirst
- ☐ Gas
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Nausea
- ☐ Rectal bleeding
- ☐ Stomach pain
- ☐ Vomiting
- ☐ Vomiting blood

CARDIOVASCULAR
- ☐ Blood Clots
- ☐ Chest pain
- ☐ High blood pressure
- ☐ Irregular heart beat
- ☐ Low blood pressure
- ☐ Murmur
- ☐ Poor circulation
- ☐ Rapid heart beat
- ☐ Swelling of ankles
- ☐ Varicose veins

EYE/EAR/NOSE/THROAT
- ☐ Bleeding gums
- ☐ Blurred vision
- ☐ Crossed eyes
- ☐ Difficulty swallowing
- ☐ Double vision
- ☐ Earache
- ☐ Ear discharge
- ☐ Hay fever
- ☐ Hoarseness
- ☐ Loss of hearing
- ☐ Nosebleeds
- ☐ Persistent cough
- ☐ Ringing ears
- ☐ Sinus problems
- ☐ Vision - Flashes
- ☐ Vision - Halos

SKIN
- ☐ Bruise easily
- ☐ Hives
- ☐ Itching
- ☐ Change in moles
- ☐ Rash
- ☐ Scars
- ☐ Sore that won't heal

MEN only
- ☐ Breast lump
- ☐ Erection difficulties
- ☐ Lump in testicles
- ☐ Penis discharge
- ☐ Sore on penis

WOMEN only
- ☐ Abnormal Pap Smear
- ☐ Bleeding between periods
- ☐ Breast Lump
- ☐ Extreme menstrual pain
- ☐ Hot flashes
- ☐ Nipple discharge
- ☐ Vaginal discharge

Date of last period_________

Date of last Pap Smear ____________

Have you had a mammogram? _________

Are you pregnant? ______

Number of children _____

CONDITIONS

Check (√) conditions you currently have or have had in the past year.

Epilepsy/Seizure disorder	Stroke	Appendicitis	Diabetes
Multiple Sclerosis	Asthma	Crohn'sDisease	Goiter
Migraine Headaches	Bronchitis	Hepatitis	Thyroid Problems
Alcoholism	Emphysema/COPD	Hernia	Anemia
Psychiatric Care	Pneumonia	Irritable Bowel	Bleeding Disorder
Cataracts	Tuberculosis	Liver Disease	Breast Lump
Glaucoma	Heart Disease	Ulcerative Colitis	Cancer
Blood Clots	Heart Attack	Ulcers, Stomach	________________ _
Congestive Heart Failure	High Blood Pressure	Prostate Problem	Herpes
Pulmonary Embolism	High Cholesterol	Kidney Failure	HIV Positive
Rheumatic Fever	Pacemaker	Kidney Stones	Arthritis
			Gout

Medications- List all medication you are currently taking with their dosage:	Allergies to Medications:

Pharmacy Name	Telephone Number	

Family History – Fill in health information about your family

Relation	Age	State of Health	Age at Death	Cause of Death	Check (√) if your blood relatives had any of the following:	Disease	Relationship to you
Father						Arthritis/Gout	
Mother						Aortic Aneurysm	
Brothers						Blood Clots	
						Cancer	
						Chemical/ETOH dependency	
						Diabetes	
						Heart Disease/Stroke	
Sisters						High Blood Pressure	
						Kidney Disease	
						Peripheral Vascular Disease	
						Varicose Veins	
						Other	

Hospitalizations/ Surgeries/ Pregnancies

Year	Hospitalization or Serious Illness/Injuries	Reason for Outcome
Year of Birth	**Sex of Birth**	**Complication if any**

Health Habits

Check (√) Which substances you use and describe how much you use.

	Caffeine	
	Alcohol	___ How much? ___ How often?
	Drugs	
	Tobacco Year Quit____	____ How many years ? ____ Packs per day?

Occupational

Check (√) if your work exposes you to the following

	Stress	Hazardous Substances	
	Heavy Lifting	Hazardous Substances	
	Other		

What is (was) your Occupation?

Have you ever had a blood Transfusion?

Yes No

If yes, please give approximate dates

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

____ ____________

Signature Date