WELCOME TO OUR PRACTICE. AS A NEW PATIENT, PLEASE FILL OUT THE INFORMATION FOUND BELOW TO THE BEST OF YOUR ABILITY.

Patient Name: ____________________________________ **Date**: _________________________________

Chief Complaint: _________________________________ **Birth date**: ____________________________

History of present illness:

Location: ____ (Where is the pain/problem?)

Quality: _______________________________ (Ex: normal vs. abnormal color, activity, etc.)

Severity: ______________________________________ (How severe is the pain/problem on a scale of 1-5 with 5 being the most severe)

Duration: ______________________________ (How long have you had this pain/problem Or, when did it start?)

Timing: ____ (Does the pain/problem occur at a specific time?)

Context: _______________________________ (Where were you at the onset of this pain problem?)

Associated signs/symptoms: ________________________
____
(What other associated problems have you been having?)

Modifying Factors: ____________________
____
(What makes the pain/problem worse or better? Or, have you had previous episodes?)

Past Medical History

Have you ever had the following: (Circle "no" or "yes", leave blank if uncertain)

Measles	no	yes	Anemia	no	yes	Back trouble	no	yes
Mumps	no	yes	Bladder Infections	no	yes	High Blood Pressure	no	yes
Chicken pox	no	yes	Epilepsy	no	yes	Low Blood Pressure	no	yes
Whooping Cough	no	yes	Migraine Headaches	no	yes	Hemorrhoids	no	yes
Scarlet Fever	no	yes	Tuberculosis	no	yes	Date of last Chest X-ray _______		
Diphtheria	no	yes	Diabetes	no	yes	Asthma	no	yes
Smallpox	no	yes	Cancer	no	yes	Hives or Eczema	no	yes
Pneumonia	no	yes	Polio	no	yes	AIDS or HIV+	no	yes
Rheumatic Fever	no	yes	Glaucoma	no	yes	Infectious Mono	no	yes
Heart Disease	no	yes	Hernia	no	yes	Bronchitis	no	yes
Arthritis	no	yes	Blood or Plasma	no	yes	Mitral Valve Prolapse	no	yes
Venereal Disease	no	yes	Transfusions	no	yes	Stroke	no	yes
Hepatitis	no	yes	Ulcer	no	yes	Kidney Disease	no	yes
Thyroid Disease	no	yes	Bleeding Tendency	no	yes			
Any other disease	no	yes						

(Please list) ____

Previous Hospitalizations/Surgeries/Serious Illnesses	**When?**	**Hospital/City/State**
______________________________________	________	______________________
______________________________________	________	______________________
______________________________________	________	______________________

Medications: (Include nonprescription)

____

____

Have you ever taken Phen-Fen/Redux? no yes

Patient Social History

Marital Status □ Married □ Single □ Widow □ Divorced

Use of Alcohol □ Never □ Rarely □ Moderate □ Daily _________

Use of Tobacco □ Nonsmoker □ Former Smoker □ Other type of tobacco use: _____________________

□ Smoker- How many a day? _________ How Often? __________ How soon after waking up? _______

Use of Drugs □ Never □Type/Frequency ____

Family Medical History

	Age	Diseases	If Deceased, Cause of Death
Father	_______	__________________________	____________________________
Mother	_______	__________________________	____________________________
Siblings	_______	__________________________	____________________________
	_______	__________________________	____________________________
	_______	__________________________	____________________________
Spouse	_______	__________________________	____________________________
Children	_______	__________________________	____________________________
	_______	__________________________	____________________________
	_______	__________________________	____________________________

Review of Systems
Please indicate any personal history below:

☐ Constitutional Symptoms

Item		
Recent weight change	no	yes
Fever	no	yes
Fatigue	no	yes
Headaches	no	yes

☐ Eyes

Item		
Eye disease or injury	no	yes
Wear glasses/contact lenses	no	yes
Blurred or double vision	no	yes

☐ Ears/Nose/Mouth/Throat

Item		
Hearing loss or ringing	no	yes
Earaches or drainage	no	yes
Chronic sinus problems/rhinitis	no	yes
Nose bleeds	no	yes
Mouth Sores	no	yes
Bleeding gums	no	yes
Bad breath or bad taste	no	yes
Sore throat or voice change	no	yes
Swollen glands in neck	no	yes

☐ Cardiovascular

Item		
Heart trouble	no	yes
Chest Pain or angina pectoris	no	yes
Palpitation	no	yes
Swelling of feet, ankles/hands	no	yes

☐ Respiratory

Item		
Persistent cough/throat Clearing not associated with a known illness (lasting more than 3 weeks)	no	yes
Spitting up blood	no	yes
Shortness of breath	no	yes
Wheezing	no	yes

☐ Gastrointestinal

Item		
Loss of appetite	no	yes
Change in bowel movement	no	yes
Nausea or vomiting	no	yes
Frequent diarrhea	no	yes
Rectal bleeding/blood in stool	no	yes
Abdominal pain		

☐ Genitourinary

Item		
Frequent Urination	no	yes
Burning or painful urination	no	yes
Blood in urine	no	yes
Change in force of strain when urinating	no	yes
Incontinence or dribbling	no	yes
Kidney stones	no	yes
Sexual difficulty	no	yes
Male-testicle pain	no	yes
Female – pain with periods	no	yes
Female – vaginal discharge	no	yes
Female – irregular periods	no	yes
Female - # of pregnancies	_______	
Female - # of miscarriages	_______	
Female – date of last pap smear	_______	

☐ Musculoskeletal

Item		
Joint pain	no	yes
Joint stiffness	no	yes
Weakness of muscles or joints	no	yes
Muscle pain or cramps	no	yes
Back pain	no	yes
Difficulty in walking	no	yes

☐ Integumentary

Item		
Rash or itching	no	yes
Change in skin color	no	yes
Change in hair or nails	no	yes
Varicose veins	no	yes
Breast pain	no	yes
Breast lump	no	yes
Breast discharge	no	yes

☐ Neurological

Item		
Frequent/recurring headaches	no	yes
Light headed or dizzy	no	yes
Convulsions or seizures	no	yes
Numbness/tingling sensations	no	yes
Tremors	no	yes
Paralysis	no	yes

☐ Psychiatric

Item		
Memory loss or confusion	no	yes
Nervousness	no	yes
Depression	no	yes
Insomnia	no	yes
Suicidal thoughts	no	yes
Violent or unusual thoughts	no	yes

☐ Endocrine

Item		
Excessive thirst or urination	no	yes
Heat or cold intolerance	no	yes
Skin becoming drier	no	yes
Change in hat or glove size	no	yes

☐ Hematologic/Lymphatic

Item		
Slow to heal after cuts	no	yes
Bleeding or bruising tendency	no	yes
Anemia	no	yes
Phlebitis	no	yes
Past transfusion	no	yes
Enlarged glands	no	yes

☐ Allergic/Immunologic

History of skin reaction or other

Item		
Penicillin or other antibiotics	no	yes
Morphine, Demorol or other narcotics	no	yes
Novocain or other anesthetics	no	yes
Aspirin or other pain remedies	no	yes
Tetanus antitoxin or other serums	no	yes
Iodine Methiolate other antiseptic	no	yes

Other drugs/medications ______________
____

Known food allergies ________________
____

Environmental allergies ______________
____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the healthcare staff to perform the necessary services I may need.

____
Patient Name

____ _______________
Signature of Patient/Parent/Guardian Date

HEALTH HISTORY