NEW PATIENT HISTORY FORM

Name:________________________________ Date of Birth:________________
Physician:________________________________ Today's Date:________________

CURRENT MEDICAL PROBLEMS ☐ None

________________ ________________ ________________ ________________
________________ ________________ ________________ ________________

PAST SURGERIES/PROCEDURES ☐ None

Year:________ Type:________________ Year:________ Type:________________
Year:________ Type:________________ Year:________ Type:________________

MEDICATIONS ☐ None
(Include ALL over-the-counter and herbal remedies)

Name Dose Frequency Name Dose Frequency

ALLERGIES: ☐ None ☐ Hay fever ☐ Pets ☐ Food________ ☐ Other________
☐ Medication (Please list below)

Medication Name Side Effect Medication Name Side Effect

PERSONAL HEALTH MAINTENANCE

Last Colonoscopy Date________________Findings________________Next Due________________
Last Bone Density Date________________Findings________________Next Due________________
In the past two weeks, have you felt down, depressed or hopeless? Y N Felt little interest or pleasure in activities? Y N
Vaccines: ☐ Pneumovax________ ☐ Prevnar________ ☐ Zostavax (Shingles)________ ☐ Tetanus________
MALE: Last prostate exam/PSA test________________Result________________
FEMALE: Last Mammogram________________Last Pelvic________________Result________________

FAMILY HISTORY (Include all health problems)

Relation to Patient	**Age**	**Diabetes**	**Hypertension**	**Heart Disease**	**Stroke**	**Cancer (Type)**	**High Cholesterol**	**Other**
Mother								
Father								
Brother(s)								
Sister(s)								
Paternal Grandfather								
Paternal Grandmother								
Maternal Grandfather								
Maternal Grandmother								
Sons(s)								
Daughter(s)								

SOCIAL HISTORY

Occupation________________________ ☐ Retired ☐ Unemployed Marital Status________
Smoking ☐ Never ☐ Former ☐ Current Packs/day______ #of years______ Quit Date________________
Other Tobacco Use________________Alcohol Use: ☐Daily ☐Weekly ☐Rare Servings________
Drug Use Type________________________How often________________
Diet________________________Exercise________________________

OTHER PHYSICIANS INCLUDED IN YOUR CARE

Name Specialty Name Specialty

PATIENT REVIEW OF SYSTEMS FORM

Name:____ Date of Birth:______________________
Physician:____ Today's Date:______________________

Do you now or have you had any problems related to the following systems? Check the appropriate box.

Constitutional Symptoms	Yes Now	Yes Past	No Never
Fever	□	□	□
Chills	□	□	□
Weakness	□	□	□
Poor Appetite	□	□	□
Weight Loss/Gain	□	□	□
Eyes	□	□	□
Blurred Vision	□	□	□
Double Vision	□	□	□
Pain	□	□	□
Glasses	□	□	□
Change in Vision	□	□	□
Allergic/Immunologic			
Hay Fever	□	□	□
Drug Allergies	□	□	□
Neurological			
Tremors	□	□	□
Dizzy Spells	□	□	□
Numbness/Tingling	□	□	□
Frequent or Severe Headaches	□	□	□
Ear/Nose/Throat/Mouth			
Ear Infection	□	□	□
Sore Throat	□	□	□
Sinus Problem	□	□	□
Difficulty Hearing	□	□	□
Earaches	□	□	□
Cardiovascular			
Chest Pain	□	□	□
Varicose Veins	□	□	□
High Blood Pressure	□	□	□
Heart Murmur	□	□	□
Irregular Heartbeat	□	□	□
Swelling of Legs	□	□	□
Use of Oxygen	□	□	□
Gastrointestinal			
Abdominal Pain	□	□	□
Nausea/Vomiting	□	□	□
Indigestion/Heartburn	□	□	□
Diarrhea	□	□	□
Blood in Stool	□	□	□
Ulcers	□	□	□
Jaundice	□	□	□
Constipation	□	□	□

Skin	Yes Now	Yes Past	No Never
Skin Rash	□	□	□
Lump/Growth on Skin	□	□	□
Boils	□	□	□
Persistent Itch	□	□	□
Change in Skin Color	□	□	□
Musculoskeletal			
Joint Pain	□	□	□
Neck Pain	□	□	□
Sore Muscles	□	□	□
Osteoporosis	□	□	□
Psychiatric			
Memory Loss/Forgetfulness	□	□	□
Depression	□	□	□
Respiratory			
Wheezing	□	□	□
Frequent Cough	□	□	□
Shortness of Breath	□	□	□
Blood in Sputum	□	□	□
Genitourinary			
Urine Retention	□	□	□
Painful Urination	□	□	□
Urinary Frequency	□	□	□
Blood in Urine	□	□	□
Discharge (penile or vaginal)	□	□	□
Hematologic/Lymphatic			
Swollen Glands	□	□	□
Enlarged Lymph Nodes	□	□	□
Blood Clotting Problems	□	□	□
Easy Bruising or Bleeding	□	□	□
Frequent Bleeding from Gums	□	□	□
Anemia	□	□	□
Endocrine			
Excessive/Increased Thirst	□	□	□
Heat/Cold Intolerance	□	□	□
Too Hot/Cold	□	□	□
Tired/Sluggish	□	□	□
GYN (females only)			
Symptomatic Hot Flashes	□	□	□
Symptomatic Vaginal Dryness	□	□	□
Difficulty Sleeping	□	□	□