

## New Patient Medical History

Name:	DOB:
Occupation:	
Who lives in home with you?	

Past Medical History: Please mark "X" for all conditions with which you have been diagnosed.

<input type="checkbox"/> Asthma	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Positive TB Skin Test
<input type="checkbox"/> Emphysema/COPD	<input type="checkbox"/> Ulcer	<input type="checkbox"/> Fibromyalgia	<input type="checkbox"/> HIV
<input type="checkbox"/> Pulmonary Embolus	<input type="checkbox"/> Cirrhosis of the Liver	<input type="checkbox"/> Gout	<input type="checkbox"/> Hepatitis A
<input type="checkbox"/> Pneumonia/Pleurisy	<input type="checkbox"/> Acid Reflux	<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Hepatitis B
<input type="checkbox"/> Stroke	<input type="checkbox"/> Diverticulosis	<input type="checkbox"/> Psoriasis	<input type="checkbox"/> Hepatitis C
<input type="checkbox"/> TIA (mini stroke)	<input type="checkbox"/> Colitis or Crohn's Disease	<input type="checkbox"/> Depression	
<input type="checkbox"/> Seizures/Epilepsy	<input type="checkbox"/> Kidney Stones	<input type="checkbox"/> Rheumatic Fever	
<input type="checkbox"/> Migraines	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Chicken Pox	
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Cancer _____	<input type="checkbox"/> Polio	
<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Anemia	<input type="checkbox"/> Mumps	
<input type="checkbox"/> Heart Attack	<input type="checkbox"/> Blood Transfusions	<input type="checkbox"/> Measles	
<input type="checkbox"/> Congestive Heart Failure	<input type="checkbox"/> Diabetes	<input type="checkbox"/> German Measles	
<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Thyroid Problems	<input type="checkbox"/> Herpes	
<input type="checkbox"/> Irregular Heart Rate	<input type="checkbox"/> Phlebitis	<input type="checkbox"/> Tuberculosis	

**Allergies:**


**Medications:** List all you are now taking. List Dose (mg) and frequency. Please include all vitamins, supplements, herbs and over the counter preparations.


**Hospital Admissions** (not including pregnancies) List years and reasons or surgeries.


**Preventive Medicine Record** (Please give date of last test or shot)

Tetanus	Eye Exam	Mammogram
Flu	Cholesterol	Pap/Pelvic
Pneumonia	Rectal/Stool	Chest X-ray
Hepatitis A	Prostate	EKG (heart)
Hepatitis B	Stress Test	Bone Density
Sigmoidoscopy		

**Health Habits/Safety** (circle)

Alcohol	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Amount	Frequency
Smoking	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> In the past	_____ ppd x _____ years
Seatbelts	<input type="checkbox"/> Always	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Never	
Guns in the house	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
Regular Exercise	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Sometimes	
Balanced Diet	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Vegetarian

Name \_\_\_\_\_ Today's Date \_\_\_\_\_

Family History: Has any blood relative had any of the following. (Circle Yes or no and indication who. Leave blank if uncertain.

	Yes	No	Relationship		Yes	No	Relationship
Cancer				Stroke			
Diabetes				Allergies			
Heart Disease				Bleeding Problems			
High Cholesterol				Alzheimer's			
High Blood Pressure				Asthma			
Thyroid Disease				Alcoholism			
Mental Illness				Osteoporosis			

Review of Systems: Please mark X for current problems

<input type="checkbox"/> Decrease in hearing	<input type="checkbox"/> Gallbladder trouble	<input type="checkbox"/> Hives-recurrent	For Women Only
<input type="checkbox"/> Ringing in ears	<input type="checkbox"/> Change in bowel habits	<input type="checkbox"/> Chronic rash	Periods started
<input type="checkbox"/> Ear Infection frequent	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Memory Loss	Age _____
<input type="checkbox"/> Dizziness	<input type="checkbox"/> Constipation	<input type="checkbox"/> Sleeping problems	Last menstrual period
<input type="checkbox"/> Fainting Spells	<input type="checkbox"/> Alternating Diarrhea/Constipation	<input type="checkbox"/> Concentration problems	Date _____
<input type="checkbox"/> Eye pain	<input type="checkbox"/> Bloody Stool	<input type="checkbox"/> Depression	Hysterectomy <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Double/Blurred Vision	<input type="checkbox"/> Hemorrhoids	<input type="checkbox"/> Agitation and/or Nervousness	Periods Regular <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Nose bleeds – recurrent	<input type="checkbox"/> Hernia	<input type="checkbox"/> Suicidal Thoughts	# Pregnancies
<input type="checkbox"/> Sinus Trouble	<input type="checkbox"/> Urinary Tract Infection–frequent	<input type="checkbox"/> Phobia	# Miscarriages
<input type="checkbox"/> Sore throats – frequent	<input type="checkbox"/> Blood in urine	<input type="checkbox"/> Moodiness	# Live births
<input type="checkbox"/> Hoarseness – prolonged	<input type="checkbox"/> Overnight urination - >2x	I am currently seeing a therapist - <input type="checkbox"/> Yes <input type="checkbox"/> No Name _____	# Abortions
<input type="checkbox"/> Bronchitis/chronic cough	<input type="checkbox"/> Loss of urination control	I may have a problem with alcohol and/or drugs. <input type="checkbox"/> Yes <input type="checkbox"/> No	Taking hormones including birth control and estrogen: <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Wheezing	<input type="checkbox"/> Unexpected weight loss ___lbs	<input type="checkbox"/> I currently have more than one sex partner	Need Birth Control <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Shortness of breath	<input type="checkbox"/> Weight gain – recent	<input type="checkbox"/> Ask me about sexual problems	Possible menopause symptoms <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Chest pain	<input type="checkbox"/> Bruise easily	<input type="checkbox"/> Ask me about family violence	
<input type="checkbox"/> Palpitations	<input type="checkbox"/> Tremors and shaking	<input type="checkbox"/> Additional information that I do not want to write down – Please ask me:	
<input type="checkbox"/> Irregular pulse	<input type="checkbox"/> Muscle weakness		
<input type="checkbox"/> Swollen ankles	<input type="checkbox"/> Numbness/tingling sensation – Where _____		
<input type="checkbox"/> Leg pain when walking	<input type="checkbox"/> Headaches - frequent		
<input type="checkbox"/> Loss of appetite	<input type="checkbox"/> Swollen joints		
<input type="checkbox"/> Difficulty swallowing	<input type="checkbox"/> Back pain - recurrent		
<input type="checkbox"/> Heartburn	<input type="checkbox"/> Bone fracture		
<input type="checkbox"/> Persistent nausea or vomiting	<input type="checkbox"/> Joint injury		
<input type="checkbox"/> Abdominal pain - chronic			

Other medical concerns/history not listed above
