NEW PATIENT HISTORY FORM

Today's Date: _______________

Name:___________________________________ Date of Birth: ____________ Age:__________

Referring Physician: _________________________ Family Physician: _________________________

What is the reason for this consultation: ____

____

Height:________ Weight:__________ Are you Right handed _______ Left handed: ________

PAST MEDICAL HISTORY: (please list all of your current medical conditions)

_____________________________________ _____________________________________

_____________________________________ _____________________________________

_____________________________________ _____________________________________

_____________________________________ _____________________________________

_____________________________________ _____________________________________

PAST SURGICAL HISTORY: (please list all major surgeries)

____________________________________ _____________________________________

____________________________________ _____________________________________

____________________________________ _____________________________________

____________________________________ _____________________________________

MEDICATIONS:

_______________________ ________________________ _______________________

_______________________ ________________________ _______________________

_______________________ ________________________ _______________________

_______________________ ________________________ _______________________

DRUG ALLERGIES: ____

SOCIAL HISTORY:

Occupation: ____________________

Marital Status: Single Married Divorced Widowed

Children: Yes No How many? __________

Education: High School College Graduate School

Tobacco Use: Yes No How much? ________________

Alcohol Use: Yes No How much? ________________

Caffeinated Beverages per day _______

Planning Pregnancy? Yes No N/A

FAMILY HISTORY: (circle all that have occurred and in which blood relative)

Migraine ______________________________

Stroke ______________________________

Seizures ______________________________

Multiple Sclerosis ______________________________

Alzheimer's Disease ______________________________

Parkinson's Disease ______________________________

Neuropathy ______________________________

Muscle Disease ______________________________

Tremor ______________________________

Review of Systems: Please indicate any personal history below:

- ***CONSTITUTIONAL SYMPTOMS***

Good general health lately	No	Yes
Recent weight change	No	Yes
Fever	No	Yes
Fatigue	No	Yes
Headaches	No	Yes

- ***EYES***

Eye disease or injury	No	Yes
Wear glasses/contact lenses	No	Yes
Blurred or double vision	No	Yes
Glaucoma	No	Yes

- ***EARS/NOSE /MOUTH/THROAT***

Hearing loss or ringing	No	Yes
Earaches or drainage	No	Yes
Chronic sinus problem or 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***

Heart trouble	No	Yes
Chest pain or angina pectoris	No	Yes
Palpitation	No	Yes
Shortness of breath with walking or lying flat.	No	Yes
Swelling of feet, ankles or hands	No	Yes

- ***RESPIRATORY***

Chronic or frequent coughs	No	Yes
Spitting up blood	No	Yes
Shortness of breath	No	Yes
Asthma or Wheezing	No	Yes

- ***GASTROINTESTINAL***

Loss of appetite	No	Yes
Change in bowel movements	No	Yes
Nausea or vomiting	No	Yes
Frequent diarrhea	No	Yes
Painful bowel movements or constipation	No	Yes
Rectal bleeding or blood in stool	No	Yes
Abdominal pain	No	Yes
Peptic ulcer (stomach or duodenal)	No	Yes

- ***GENITOURINARY***

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 - irregular periods	No	Yes
Female - vaginal discharge	No	Yes
Female - # of pregnancies	________	
Female - # of miscarriages:	________	
	________	

- ***MUSCULOSKELETAL***

Joint Pain	No	Yes
Joint stiffness or swelling	No	Yes
Weakness of muscles or joints	No	Yes
Muscle Pain or cramps	No	Yes
Back Pain	No	Yes
Cold extremities	No	Yes
Difficulty in walking	No	Yes

- ***INTEGUMENTARY (skin, breast)***

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***

Frequent or recurring headaches	No	Yes
Light headed or dizzy	No	Yes
Convulsions or seizures	No	Yes
Numbness or tingling sensations	No	Yes
Tremors	No	Yes
Paralysis	No	Yes
Stroke	No	Yes
Head injury	No	Yes

- ***PSYCHIATRIC***

Memory loss or confusion	No	Yes
Nervousness	No	Yes
Depression	No	Yes
Insomnia	No	Yes

- ***ENDOCRINE***

Glandular or hormone problem	No	Yes
Thyroid disease	No	Yes
Diabetes *(insulin or non insulin - circle one)*	No	Yes
Excessive thirst or urination	No	Yes
Heat or cold intolerance	No	Yes
Skin becoming dryer	No	Yes
Change in hat or glove size	No	Yes

- ***HEMATOLOGIC/LYMPHATIC***

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 adverse reaction to:

Penicillin or other antibiotics	No	Yes
Morphine, Demerol, 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 or other antiseptic	No	Yes

Other drugs/medications: ______________________________

Known food allergies: ______________________________

Environmental allergies: ______________________________

Reviewed by:______________________________ Date:______________