New Patient History

Name:_____ **Date of Birth:**_____ **Current Age:**_____ **Today's Date:** _____

Referring Physician:_____ **Primary Care Provider:** _____

Reason for Today's Appointment:

_____

_____

Past Medical History:

__Stroke or TIA
__Diabetes
__High blood pressure
__High cholesterol
__Heart disease
__Peripheral vascular disease
__Seizures
__Concussion
__Migraine
__Anxiety
__Depression
__Hypothyroidism
__Lung disease
__Sleep apnea: Do you use CPAP? No / Yes
__History of cancer: _____
__Kidney disease
__Bleeding disorder
__Reflux
__Ulcers
__Arthritis
__Cataracts
For Women: Are you pregnant? N / Y

Other Conditions:

_____

_____

Prior Surgeries and Dates:

_____

_____

Medication Allergies: _____

Medications: (Include all prescriptions and over-the-counter medications, including vitamins, supplements, and herbs)

Name	Dosage	Frequency

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New Patient History (Continued)

Patient Name: _____

Symptoms:

___ Recent weight loss; ___ lbs
___ Recent weight gain; ___ lbs
___ Fever
___ Night sweats
___ Fatigue
___ Blurred Vision
___ Double vision
___ Blindness
___ Hearing loss
___ Ringing in ears
___ Chest pain
___ Palpitations
___ Shortness of breath
___ Swelling of feet or ankles
___ Fainting
___ Frequent cough
___ Difficulty breathing
___ Coughing up blood
___ Productive Cough
___ Nausea
___ Frequent indigestion
___ Black, tarry or bloody stools
___ Difficulty urinating
___ Incontinence
___ Burning with urination
___ Excessive thirst
___ Unusual appetite
___ Frequent urination
___ Rashes
___ Recent change in wart/mole
___ Easy bleeding or bruising
___ Depression
___ Anxiety
___ Difficulty falling asleep
___ Early morning awakenings
___ Feeling persistently sad or blue
___ Loss of ability to enjoy life

Is today's visit related to an injury? No / Yes - Date: _____

Family History:

Father: Alive / Deceased, Medical Conditions: _____
Mother: Alive / Deceased, Medical Conditions: _____
Siblings: # of Brothers _____ # of Sisters _____ Medical Conditions: _____
Number of Children: _____ Medical Conditions: _____
Does anyone in your family have symptoms similar to yours? _____
Are any medical conditions prominent in your family?

Social History:

Birth Place: _____ Education: _____ Occupation: _____
Marital Status: _____ Who lives with you? _____
Number of caffeinated beverages per day (e.g. coffee, soda, tea): _____
Smoking: No / Yes - Packs per day: _____ Number of years smoked: _____ Quit date: _____
Alcohol: No / Yes - Amount per week: _____ Have you recently tried to cut down? _____
Marijuana: No / Yes - Frequency: _____ Other Drugs: No / Yes - Which: _____