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; Amount: ___
__Recent weight gain; Amount: ___
__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
__Snoring/gasping for air at night
__Trouble 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 or 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: _____
Children: # of Sons: _____ # of Daughters: _____ 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?: _____
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?: No / Yes
Marijuana: No / Yes – Frequency: _____Other Drugs: No / Yes – Which: _____
Number of caffeinated beverages per day (e.g. coffee, soda, tea):_____
Name and relation of others with you today: _____

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