

New Patient Medical History Form

Patient Name _____ Today's Date _____

Age ____ Birth date _____ Date of last physical examination _____ Referring Physician _____

What is your reason for visit? _____

SYMPTOMS

Check (√) conditions you currently have or have had in the past year

GENERAL

- Chills
- Depression
- Dizziness
- Fainting
- Fever
- Forgetfulness
- Headache
- Loss of sleep
- Loss of weight
- Nervousness
- Numbness
- Sweats

MUSCLE/JOINT/BONE

Pain/ weakness/numbness in:

- Arms Hips
- Back Legs
- Feet Neck
- Hands Shoulders

GENITO-URINARY

- Blood in urine
- Frequent urination
- Lack of bladder control
- Painful urination

GASTROINTESTINAL

- Appetite poor
- Bloating
- Bowel changes
- Constipation
- Diarrhea
- Excessive hunger
- Excessive thirst
- Gas
- Hemorrhoids
- Indigestion
- Nausea
- Rectal bleeding
- Stomach pain

Vomiting

Vomiting blood

CARDIOVASCULAR

- Blood Clots
- Chest pain
- High blood pressure
- Irregular heart beat
- Low blood pressure
- Murmur
- Poor circulation
- Rapid heart beat
- Swelling of ankles
- Varicose veins

EYE/EAR/NOSE/THROAT

- Bleeding gums
- Blurred vision
- Crossed eyes
- Difficulty swallowing
- Double vision
- Earache
- Ear discharge
- Hay fever
- Hoarseness
- Loss of hearing
- Nosebleeds
- Persistent cough
- Ringing ears
- Sinus problems
- Vision - Flashes
- Vision - Halos

SKIN

- Bruise easily
- Hives
- Itching
- Change in moles
- Rash
- Scars
- Sore that won't heal

MEN only

- Breast lump
- Erection difficulties
- Lump in testicles
- Penis discharge
- Sore on penis

WOMEN only

- Abnormal Pap Smear
- Bleeding between periods
- Breast Lump
- Extreme menstrual pain
- Hot flashes
- Nipple discharge
- Vaginal discharge
- Date of last period _____
- Date of last Pap Smear _____
- Have you had a mammogram? _____
- Are you pregnant? _____
- Number of children _____

CONDITIONS

Check (√) conditions you currently have or have had in the past year.

- Alcoholism
- Chemical Dependency
- Psychiatric Care
- Anemia
- Bleeding Disorder
- Breast Lump
- Cancer
- Herpes
- HIV Positive
- Multiple Sclerosis

- Appendicitis
- Crohn's
- Hepatitis
- Hernia
- Irritable Bowel
- Ulcerative Colitis
- Ulcers
- Arthritis
- Gout

- Asthma
- Bronchitis
- Emphysema/COPD
- Pneumonia
- Tuberculosis
- Diabetes
- Goiter
- Thyroid Problems

- Heart Disease
- Heart Attack
- Congestive Heart Failure
- High Blood Pressure
- Blood Clots
- Pulmonary Embolism
- Rheumatic Fever
- Pacemaker
- High Cholesterol

- Epilepsy/Seizure disorder
- Migraine Headaches
- Stroke
- Kidney Failure
- Kidney Stones
- Liver Disease
- Prostate Problem
- Cataracts
- Glaucoma

Medications – List all medications you are currently taking

Allergies – List Medications - ONLY

Pharmacy Name _____

Telephone # _____

Family History – Fill in health information about your family

Relation	Age	State of Health	Age at Death	Cause of Death	Check (√) if your blood relatives had any of the following: Disease Relationship to you	
Father					Arthritis/Gout	
Mother					Aortic Aneurysm	
Brothers					Blood Clots	
					Cancer	
					Chemical/ETOH dependency	
					Diabetes	
					Heart Disease/Stroke	
Sisters					High Blood Pressure	
					Kidney Disease	
					Peripheral Vascular Disease	
					Varicose Veins	
					Other	

Hospitalizations -			Pregnancies -		
Year	Hospital	Reason for Hospitalization and Outcome	Year of Birth	Sex of Birth	Complication if any

			Health Habits		
			Check (√) Which substances you use and describe how much you use.		
				Caffeine	
Have you ever had a blood Transfusion? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please give approximate dates				Alcohol	
Serious Illness/Injuries				Drugs	
	Date	Outcome		Tobacco Year Quit	____ How many years ____ Packs per day

			Occupational		
			Check (√) if your work exposes you to the following		
				Stress	
				Heavy Lifting	
					Hazardous Substances
					Other
			Occupation		

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature

Date