

**NEW PATIENT HISTORY FORM**

**Last Name** \_\_\_\_\_ **First Name** \_\_\_\_\_ **Middle** \_\_\_\_\_

**Today's Date** \_\_\_\_/\_\_\_\_/\_\_\_\_ **Age** \_\_\_\_\_ **Date of Birth** \_\_\_\_/\_\_\_\_/\_\_\_\_

**Phone: Home** \_\_\_\_\_ **Work** \_\_\_\_\_ **Cell** \_\_\_\_\_

Please indicate prefer number to call.

**Mailing Address:** \_\_\_\_\_

**Referring Physicians Name** \_\_\_\_\_ **Primary Care Physician** \_\_\_\_\_

**Main Reason for today's visit:**  
 \_\_\_\_\_

Answers on this form will help your health care provider better understand your medical concerns and conditions. If you cannot remember specific details, please provide your best guess.

**Personal Medical History:** please indicate whether you have had any of the following medical problems, (Please indicate with a yes or no.)

**Yes No**

Heart Disease: (type) \_\_\_\_\_

Do you have cardiac stents? \_\_\_\_ What type? \_\_\_\_\_

If yes: When was it placed and by whom? \_\_\_\_\_

Do you have a pacemaker, mechanical or replacement valve, or other implants? \_\_\_\_\_

If yes: When was it placed and by whom? \_\_\_\_\_

Have you ever had a Myocardial Infarction (Heart Attack)? \_\_\_\_\_

If yes: When did you have the heart attack? \_\_\_\_\_

Do you experience Angina (Chest Pain)? \_\_\_\_\_

If yes: How do you manage the episode? \_\_\_\_\_

Who is your cardiologist? \_\_\_\_\_

High Blood Pressure

High Cholesterol

Diabetes (specify) type I \_\_\_\_ or type II \_\_\_\_

Thyroid Problem

Gout

Asthma/Lung Disease

Kidney disease

Kidney stones

Hepatitis A \_\_ B \_\_ C\_\_

Stroke / Cerebral Vascular Accident/ Transient Ischemic Attack

Multiple Sclerosis

Parkinson's disease

Alzheimer/Dementia

Gastroesophageal Reflux Disease (GERD)

**Personal Medical History: (Continued)**

Yes No

- Gastrointestinal disease: Crohn's Disease \_\_\_\_\_  
Irritable Bowel Syndrome \_\_\_\_\_  
Clostridium Difficile Colitis (C. Difficile, or C. Dif) \_\_\_\_\_
- Cancer (type) \_\_\_\_\_  
Who is your oncologist? \_\_\_\_\_
- Back problems/Spinal Cord Injury
- Joint replacement (which joint) \_\_\_\_\_  
If yes: When was it replaced? \_\_\_\_\_ Who was the orthopedic surgeon? \_\_\_\_\_
- Cataracts
- Glaucoma
- Has it been recommended that you take antibiotics prior to dental or other procedures?

**Surgical History:**

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**Allergies & reactions to medications:**

Allergy:	Reaction:	Allergy:	Reaction:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**Please list the medications and/or over-the-counter, herbal supplements, vitamins, or homeopathic intake. Medications:** Prescriptions, Over-the-counter, Herbal, Vitamins, or Homeopathic: Please include: **Anti-coagulants: (Blood Thinners) including, aspirin, coumadin, (warfarin), plavix, (clopidogrel).**

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**Pharmacy Name** \_\_\_\_\_ **Location** \_\_\_\_\_

**Family History: Please indicate yes or no, if your grandparents, parents, or brothers/sisters have had the following conditions:**

	Yes	No		Yes	No
Alzheimer/ Dementia	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>
Asthma/COPD	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Stones	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Obstructive Pulmonary Disease			High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>

**Family History: (Continued)**

	Yes	No		Yes	No
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Gout	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>			
Type _____					

**Social History:**

Cigarettes  never  quit (when) \_\_\_\_\_  
 Current Smoker: packs/day \_\_\_\_\_ # of years \_\_\_\_\_  
Other tobacco  yes  no type \_\_\_\_\_ amount \_\_\_\_\_

**Alcohol Use:**

Do you drink alcohol?  yes  no # drinks/week \_\_\_\_\_

**Do you drink caffeinated beverages?** Please list how much every day:

Coffee \_\_\_\_\_ Tea \_\_\_\_\_  
Soda \_\_\_\_\_ Other \_\_\_\_\_

Please indicated the number of children if here for a vasectomy consult \_\_\_\_\_

**REVIEW OF SYMPTOMS:** Please check any **current** symptoms you have.

**General**

_____ Recent fevers/sweats	_____ Chills	_____ Unexplained weight loss/gain
_____ Change in appetite	_____ Unexplained fatigue	_____ Sleeping difficulty
_____ Headaches		

**Skin**

\_\_\_\_\_ Rash \_\_\_\_\_ Non healing lesions

**Eyes/ Ears/Nose/Throat/Mouth**

_____ Glaucoma	_____ Ear pain	_____ Persistent sore throat
_____ Blurring or double vision	_____ Hay fever	_____ Difficulty hearing
_____ Cataracts	_____ Allergies	_____ Ringing in ears
_____ Glasses/Contacts	_____ Congestion	_____ Trouble swallowing

**Respiratory**

_____ Asthma	_____ Cough/wheeze	_____ Shortness of breath
_____ Chronic Obstructive Pulmonary Disease (COPD)		_____ Emphysema
_____ Tuberculosis	_____ Coughing up blood	

**Cardiovascular**

_____ Chest pain	_____ Palpitations	_____ Heart attacks
_____ Shortness of breath with exertion	_____ Swelling in extremities	_____ Stroke
_____ Heart murmur	_____ Pacemaker/defibrillator	_____ Valve replacement

