

Name _____

Chart # _____

NEW PATIENT MEDICAL HISTORY

Height _____ Weight _____ Shoe Size R _____ L _____

Date of last physical exam: _____

Doctor: _____

HABITS

Tobacco smoking (check one) Never smoked Used to smoke: If so, month/year that you quit smoking _____/____ Currently smoking (any use within past two weeks)

Type of tobacco smoked (check all that you use):

Cigarettes Pipe Cigars

Amount of tobacco used: When smoking, the most per day: _____ packs per day.

Oral tobacco use: Never used Used to chew or dip but quit.
 Currently using oral tobacco (any use within one week)

Have you ever used nicotine replacement therapy (gum or patches) No Yes

If yes, indicate type Gum Patch Both gum and patch

Alcohol use: None, never. Drank alcohol in the past, year started _____ Date quit month/year _____/____.

Current use: Average _____ drink per day or average _____ drinks per week (one drink equals one can of beer, one glass of wine, or one jigger of liquor)

Illicit drug use: None, never. Used drugs in the past, year started _____

Date quit month/year _____/____

Illicit drug used in the past: _____

Currently using

PREVENTATIVE HEALTH HISTORY

Date of last colonoscopy _____

Date of last prostate screening _____

Date of last pap smear _____

Date of last mammogram _____

Date of last cardiac stress test _____

Date of last cholesterol check _____

SOCIAL HISTORY

Current or last occupation _____ Marital status Single

Widowed, if so, year widowed _____. Married, if so, year married _____.

Separated, if so, year separated _____. Divorced, if so, year divorced _____.

Number of times married _____.

Children? No Yes Total number of children _____

If female, total number of pregnancies _____

Medical History and Patient Information

Patient's Name _____

Please indicate gender, hometown and age of all living children

Please list your daily physical activities: Sedentary Walk 20 minutes a day
 Exercise regularly (please list type of exercise you do routinely): _____

REVIEW OF SYSTEMS

Please check each item that applies to you.

Constitutional (general):

Weight loss/+10 lbs. Weight gain/+15 lbs. Fever Other _____
 Fatigue Nausea Chills

Eyes, Ears, Nose & Throat:

Impaired sight Eye disease Eye pain Vision problems
 Eye infections-frequent Glaucoma Hearing loss Ringing in ears
 Ear infections Dizzy spells Fainting spells Nose bleeds
 Breathing difficulties Sinus problems Sore throat Hoarseness
 Speech difficulties Dental problems Infected teeth (abscessed)

Respiratory:

Pneumonia/Pleurisy Emphysema Obstructive sleep apnea
 Bronchitis Allergies History of smoking
 Asthma COPD Other _____
 Shortness of breath Limited exercise tolerance
 Tuberculosis Use of oxygen at home

Cardiovascular:

Chest Pain Varicose feet Phlebitis
 Open heart surgery Cold, numb feet Pacemaker
 Heart attack Angina, increased in intensity Artificial heart valve
 Heart murmur Angina, increase occurrence High cholesterol
 High blood pressure Angina, new onset at rest Tiredness in legs
 Swelling ankles and feet Change in chest pain pattern Blocked artery
 Palpitations Irregular beat/pulse Coumadin therapy
 Mitral valve prolapse Angioplasty Stroke
 Rheumatic fever Circulation disorder TIA
 Leg pain with walking Leg pain at rest

Gastrointestinal:

Loss of appetite Cirrhosis Excessive hunger Difficulty swallowing
 Heartburn Diarrhea Peptic ulcer Vomiting
 Abdominal pain Diverticulosis Gall bladder problem Jaundice
 Hepatitis A Crohn's/colitis Excessive thirst
 Hepatitis B Bloody or black stools Persistent nausea
 Hepatitis C Reflux esophagitis Liver problems

Medical History and Patient Information

Patient's Name _____

Bladder/Kidney:

- Frequent urination Bladder infections Blood in urine Kidney stone
 Renal failure Swelling of feet Renal insufficiency

Female:

- Sexual transmissive disease Breast cancer Ovarian cancer Oral contraceptives
 Cervical cancer Other abnormal Pap smear

Male:

- Sexual transmissive disease Prostate cancer Other problems _____

HEMATOLOGIC (BLOOD DISORDERS)

- Anemia Bruise easily Cancer Blood transfusion
 Sickle cell disease/trait Take Coumadin Low iron Low B12

ENDOCRINE:

- Osteoporosis Thyroid disease, if so please indicate one of the following:
 Hypothyroid (low) Hyperthyroid (high) Goiter (enlarged) Diabetes ? Yes No
If yes, date diagnosed (month/year) _____/_____. If so, started on diabetic diet _____, on oral
diabetic medicines _____, on insulin _____. Eye disease due to diabetes Kidney problem due to
diabetes Nerve problem due to diabetes
Foot or leg ulcers, if so, indicate which foot and date Right Left Date: _____/_____
-
-

NEUROLOGIC (NERVOUS):

- Seizures Tremor/hands shake Headaches/frequent Stroke
 Change in memory Trouble with balance Spine disease Sciatica
 Numbness Muscle weakness Polio Change in
 Migraines Muscle tension headaches Visual headache sensation
 Dizziness

BONE AND JOINT:

- Arthritis Rheumatism Back pain-recurrent Gout
 Osteoporosis Osteoarthritis Rheumatoid arthritis
 Artificial joints _____ Severe arthritis of TMJ (jaw) or neck
 Osteopenia

SKIN:

- Color change mole/wart Hives Other _____
 Rashes New Growths
 Skin cancer Psoriasis
 Thick scar or keloid formation Eczema

PSYCHIATRIC:

- Sleeping difficulty Concentration difficulty Depression Nervousness
 Agitation Memory loss Moodiness Suicidal thoughts
 Phobias Mental illness Feelings of worthlessness

Medical History and Patient Information

Patient's Name _____

CHILDHOOD ILLNESSES:

- Rheumatic fever Scarlet fever Chicken pox Mumps
 Measles Herpes

IMMUNOLOGY:

- HIV Weak immune system Chronic fatigue syndrome
 Frequent infections

ALLERGIES: (Please indicate exact reaction to each):

- Hay fever Sulfa drugs Other _____
 Penicillin Any antibiotic _____
 Novocaine Cortisone _____
 Codeine Grass, mold, dust _____
 Tape Food allergies
 Mercurials No known allergies

MEDICATIONS:

Please list any and all medications now being taken (with dosage).

Name of Medication	Reason for Taking It	How Often Do You Take It?

(Please use additional space if needed for additional medications)

Have you taken Prednisone over the past 6 months? Yes No

SURGERIES AND HOSPITALIZATIONS

List previous surgeries and hospitalizations, dates and reasons.

Previous Surgeries/Hospitalizations	Approximate Dates	Reason

Medical History and Patient Information
 Patient's Name _____

FAMILY MEDICAL HISTORY

Mother __ Living __ Deceased Cause of Death _____
 Father __ Living __ Deceased Cause of Death _____
 Brother __ Living __ Deceased Cause of Death _____
 Sister __ Living __ Deceased Cause of Death _____

Has anyone in your family ever been treated for:

Diseases	You	Father	Mother	Brother	Sisters	Children	Relatives
Arthritis							
Cancer							
Diabetes							
Foot Problems							
Gout							
Neuromuscular disease							
Peripheral vascular disease							
Tuberculosis							
Varicose veins							
Heart disease							
Bleeding disorder							
Stroke							

I understand that honest and complete answers to each question stated above are important to the provision of my medical care and I have answered them to the best of my ability. I have been informed that if I am uncertain about any question on the form I should ask the doctor or a member of the office staff for assistance. The above information is true and correct.

Patient signature _____ Date _____

Physician Review _____ Date _____