NEW PATIENT HISTORY FORM

NAME (Last, First, Middle)	AGE	BIRTHDATE	SEX

HOME PHONE	WORK PHONE	OCCUPATION	MARITAL STATUS
			☐ S ☐ M ☐ W ☐ D

EMERGENCY CONTACT	CONTACT'S PHONE	IF MARRIED, SPOUSE'S NAME

PREVIOUS PHYSICIAN	CURRENT PHYSICIAN

WHICH **LOCAL** PHARMACY DO YOU USE?

HOW DID YOU HEAR ABOUT OUR PRACTICE?

ALLERGIES TO MEDICATIONS, X-RAY DYES, OR OTHER SUBSTANCES: ☐ NO ☐ YES

(If yes, please list name of medicine and type of reaction)

_____ _____

_____ _____

PAST MEDICAL HISTORY AND REVIEW OF SYSTEMS

(Please check off if you have had any problems with or are presently experiencing any of the following)

☐ High blood pressure	☐ Asthma	☐ Constipation	☐ Thyroid disease	☐ Blood disorders
☐ Diabetes	☐ Emphysema	☐ Diarrhea	☐ Head or neck radiation	☐ Venereal diseases
☐ Cancer	☐ Bronchitis	☐ Blood in stool	☐ Headache	☐ Anxiety
☐ Chest pain/chest tightness	☐ Pneumonia	☐ Ulcers	☐ Kidney disease	☐ Depression
☐ Shortness of Breath	☐ TB	☐ Change in bowel habits	☐ Kidney stones	☐ Anemia
☐ Swollen ankles	☐ Persistent cough	☐ Unexplained weight gain/loss	☐ Difficulty urinating	☐ Alcohol abuse
☐ Palpitations	☐ Abdominal discomfort	☐ Hemorrhoids	☐ Arthritis	☐ Drug abuse
☐ Lightheadedness	☐ Indigestion	☐ Gall Bladder disease	☐ Low back problems	☐ Impotence or Erectile Dysfunction
☐ Frequent urination	☐ Nausea	☐ Colitis	☐ Gout	
☐ Rheumatic fever	☐ Vomiting	☐ Hepatitis or jaundice	☐ Skin diseases	☐ Other (list below)

_____

_____

_____

_____

_____

WOMEN ONLY:

Menstrual Periods

Age onset: _____ Periods regular or irregular: _____ Still having periods: ☐ Yes ☐ No

Date of last period: _____ Difficulty with periods: _____

Pregnancies: _____ Births: _____ Miscarriages: _____ Abortions: _____

Leakage of Urine: ☐ No ☐ Yes (Please describe) _____

Pelvic pain: ☐ No ☐ Yes (Please describe) _____

Abnormal discharge ☐ No ☐ Yes (Please describe) _____

History of abnormal Pap Smear ☐ No ☐ Yes (Please describe) _____

Copies of all forms are available on our website:
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Review Date: _____

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OPERATIONS AND THEIR DATES:

☐ Tonsillectomy _____ ☐ Appendectomy _____ Hysterectomy _____ ☐ Hernia Repair _____

☐ Gallbladder _____ ☐ Other (please list) _____

_____ _____

_____ _____

HOSPITALIZATIONS (Other than surgical and childbirth)

_____

_____

_____

ACCIDENTS

_____

_____

FAMILY HISTORY	**MOTHER**	**FATHER**	**SIBLINGS**
Cancer (describe type)	_____	_____	_____
Hypertension (high blood pressure)	_____	_____	_____
Heart Disease	_____	_____	_____
Diabetes	_____	_____	_____
Strokes	_____	_____	_____
Mental disease (anxiety, depression etc.)	_____	_____	_____
Drug or alcohol addiction	_____	_____	_____
Glaucoma	_____	_____	_____
Bleeding diseases	_____	_____	_____
Other_____	_____	_____	_____

HABITS

☐ Smoking	Duration _____	Amount _____	Quit? When? _____
☐ Alcohol	Duration _____	Amount _____	Quit? When? _____
☐ Coffee/Caffeine	Duration _____	Amount _____	Quit? When? _____
☐ Drugs	Duration _____	Amount _____	Quit? When? _____

MEDICATIONS (Prescriptions, over-the-counter, vitamins, herbs, etc.)

DRUG NAME	DOSE	DRUG NAME	DOSE
_____		_____	
_____		_____	
_____		_____	
_____		_____	
_____		_____	

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TEST AND IMMUNIZATIONS

	Yes	Year Performed	Not Sure	Never	Comments
Pap Smear (Women)	☐	_____	☐	☐	_____
Breast Mammography	☐	_____	☐	☐	_____
Sigmoidoscopy	☐	_____	☐	☐	_____
Stool Occult Blood	☐	_____	☐	☐	_____
EKG	☐	_____	☐	☐	_____
Tetanus (DT)	☐	_____	☐	☐	_____
Pneumovax	☐	_____	☐	☐	_____

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