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New Patient Information Form

Please fill in this form to the best of your ability. Check boxes or supply dates where requested.

Your Name: _____ Today's Date: __/__/__

Occupation: _____ Date of Birth: __/__/__ Age: ____

Brief statement of current problem: _____

_____

Physicians: **LIST ONLY PHYSICIANS WHO ARE TO RECEIVE NOTES:**

Referring Physician: _____ Gynecologist: _____

Primary Care Physician: _____ Cardiologist: _____

Other: _____

MEDICAL HISTORY:

	Yes	No	Date
Hypertension	☐	☐	
High Cholesterol	☐	☐	
Sleep Apnea	☐	☐	
Diabetes	☐	☐	☐ Type 1 ☐ Type 2
Blood Clots: Legs	☐	☐	__/__/__
Lungs	☐	☐	__/__/__
Stroke/TIA	☐	☐	__/__/__
Hepatitis	☐	☐	B ☐ C ☐
Cancer	☐	☐	Describe:

Cardiac Disease:	Yes	No	Date
Angina	☐	☐	
MI	☐	☐	__/__/__
Bypass	☐	☐	__/__/__
Stent	☐	☐	__/__/__
Angioplasty	☐	☐	__/__/__

Lung Disease:	Yes	No
COPD	☐	☐
Asthma	☐	☐
Emphysema	☐	☐
Shortness of Breath	☐	☐
Blood transfuse	☐	☐
HIV/AIDS	☐	☐

Other: _____

Other Medical Problems Please check any problem you have had or currently have:

General
- ☐ Weight Loss
- ☐ Fevers
- ☐ Night Sweats
- ☐ Chills

Ear/Nose/Throat
- ☐ Hard of Hearing
- ☐ Ringing in Ears
- ☐ Ear Infections
- ☐ Hearing Aids
- ☐ Hoarseness
- ☐ Sore Throat
- ☐ Voice Changes
- ☐ Throat Polyps

Eyes:
- ☐ Vision Problems
- ☐ Glasses/Contacts
- ☐ Glaucoma

Respiratory
- ☐ Wheezing
- ☐ coughing
- ☐ Pneumonia

Cardiovascular
- ☐ Palpitations
- ☐ Murmur
- ☐ Chest Pain

Gastrointestinal
- ☐ Difficulty Swallowing
- ☐ Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Bloody Stools
- ☐ Change in Bowel Habits
- ☐ Heartburn
- ☐ Abdominal Pain
- ☐ Inflammatory Bowel Dis. Colitis
- ☐ Ulcers
- ☐ Hemorrhoids
- ☐ Jaundice
- ☐ Diverticulitis

Endocrine
- ☐ Thyroid Problems
- ☐ Goiter
- ☐ Calcium Problems

Genitourinary:
- ☐ Burning Upon Urination
- ☐ Impotence
- Prostate Problems
- ☐ Kidney Stones
- ☐ Menstrual Problems

Musculoskeletal:
- ☐ Broken Bones
- ☐ Sprains
- Arthritis
- ☐ Swollen Joints
- ☐ Osteoporosis

Skin
- ☐ Rash
- ☐ Skin cancer
- ☐ melanoma
- ☐ nonhealing wounds

Immunologic
- ☐ frequent infections
- ☐ allergies

Neurologic
- ☐ headaches
- ☐ seizures
- ☐ fainting
- ☐ migraines
- ☐ loss of speech
- ☐ Paralysis
- ☐ memory loss

hematologic
- ☐ anemia
- ☐ enlarged spleen
- ☐ frequent nosebleeds
- ☐ easy bruising
- ☐ painful lymph nodes
- ☐ swollen lymph nodes
- ☐ Jaundice
- ☐ Diverticulitis

Psychological:
- ☐ Depression
- ☐ Panic Attacks
- ☐ anxiety

other: _____

ALLERGIES Yes No Describe (list drug and reaction):

Medications ☐ ☐ _____

Latex ☐ ☐ _____

Other ☐ ☐ _____

PREVIOUS SURGERIES (throughout lifetime):

	Procedure	Year
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____
5.	_____	_____
6.	_____	_____
7.	_____	_____
8.	_____	_____

FAMILY HISTORY: If any blood relative has suffered any of the following, please check and indicate which relative.

	Yes	No			Yes	No	
Diabetes	☐	☐	_____	Stroke	☐	☐	_____
Bleeds Easily	☐	☐	_____	High Blood Pressure	☐	☐	_____
Heart Disease	☐	☐	_____				

FAMILY HISTORY OF CANCER (relatives):

Breast _____ Cervical _____ Ovarian _____

Uterine _____ Prostate _____ Colon _____

Other _____

SOCIAL HISTORY:

Smoking: Never ☐

Current ☐ Age when started_____ How long? _____ Amount per day _____

Previous ☐ Age when started_____ How long? _____ Date stopped: ___/___/___ Amount per day_____

Alcohol: Never ☐ Previous ☐ Current ☐ Amount: _____

Drugs: Never ☐ Previous ☐ Current ☐ Type: _____

Ever received drug treatment? Yes ☐ No ☐ Ever used injectable needles? Yes ☐ No ☐

Breast patients only

Age at first menstrual period _____ Last menstrual period_____ Age at menopause _____

Number of children _____ Age at first child birth_____

Did you breast feed _____ Duration of breast feeding _____ Complications _____

MEDICATION LIST

Home medications for reconciliation for present office visit.

If you brought a list of your medications, please give it to the receptionist so a copy can be made. Otherwise, complete the following:

Patient Name: _____, _____ _____

Last Name First Name MI

Date of Birth: ____/____/_____ Date List Completed: ____/____/_____

Person Completing List: _____, _____ _____

(If other than patient) Last Name First Name MI

Medication	Dose	Frequency	Reason for Medication	Route (by mouth, eye drops, injection, etc.)
1)				
2)				
3)				
4)				
5)				
6)				
7)				
8)				
9)				
10)				
11)				
12)				
13)				
14)				
15)				
16)				
17)				
18)				

Over-the-Counter Medications (Aspirin, vitamins, herbal supplements, etc.):

_____ _____ _____

_____ _____ _____

_____ _____ _____