New Patient Health History

Patient's Name:_____ Date: _____

Emergency Contact Information

Name: _____ Relationship:_____

Home Phone:_____ Mobile Phone:_____

Medical History

_____

_____

_____

Surgical History

_____

_____

_____

Review of Symptoms

Do you have or have you had any of these symptoms? (Please check any that apply or write any similar symptoms).

- o Anemia/Easy Bruising _____
- o Headaches/Seizures_____
- o Vision Problems or Changes_____
- o Hearing Loss, Tinnitus, Earache, Discharge_____
- o Nosebleeds, Sinus Problems_____
- o Swallowing Difficulties_____
- o Cardiac Issues, Heart Palpitations _____
- o Shortness of Breath/Chest Pain/Edema/Heart Palpitations_____
- o Indigestion, Reflux, Ulcers_____
- o Abdominal Pain/Diarrhea/Constipation_____
- o Unexplained Weight loss/Fatigue/Nausea/Chills/Night sweats/Insomnia_____
- o Mood Swings/Anxiety/Depression_____
- o Coughing/Wheezing_____
- o Rashes/Lumps/Itching/Hair or Nail Changes_____
- o Urinary Problems/Painful Urination/Bloody Urine_____
- o Other_____
- o None _____

Patient's Name:_____ Date: _____

Family History
Has anyone in your family had any of these conditions?

Condition: Person(s) Affected:

- Diabetes_____
- High Blood Pressure_____
- Emphysema (or lung problems)_____
- Osteoporosis_____
- Lupus or other Rheumatologic Conditions_____
- Heart Problems _____
- Kidney Problems _____
- Anxiety/Depression _____
- Headaches _____
- Stomach or Duodenal Ulcer _____
- Cancer (site)_____
- Other _____

Current Pain Medications (Include dose if known)

_____

_____

_____

Current Other Medications AND Reason for Taking:
(Include over the counter medications such as Tylenol, Motrin, nasal sprays and vitamins).

_____

_____

_____

Drug Allergies and Reactions O No Known Drug Allergies

_____

_____

_____

Social History

Do you currently smoke: Yes /No Number of years you smoked:_____ Packs per day:_____

How much do you drink? :_____ Daily Weekly

Patient's Signature:_____