Health History

New Patient

Today's Date _____
Name _____
Date of Birth _____
MR# _____

Thank you for choosing our clinic. **Please complete ALL sections**

Primary Care Physician (PCP) _____ PCP Phone No. _____

Preferred Pharmacy _____ Pharmacy Phone No. _____

Who referred you to us: _____

1. Chief Concern: Please describe the reason for your visit today.

_____

2. Past Medical History: Have you ever had any of the following: *(please check all those that apply)*

☐ Diabetes	☐ Osteoporosis/Osteopenia	☐ Cancer
☐ High Blood Pressure	☐ Stroke / Mini Stroke	☐ Kidney Stones
☐ High Cholesterol	☐ Asthma	☐ Thyroid Problems
☐ Heart Attack	☐ Lung Disease	☐ Other _____

3. Past Surgical History: *Please list any prior surgeries*

Surgery _____ Year _____
Surgery _____ Year _____
Surgery _____ Year _____

4. Pregnancy

Are you Pregnant? ☐ No ☐ Yes Due Date: _____ Last Menstrual Period: _____

Pregnancies? ☐ No ☐ Yes How many children do you have? _____
Are you nursing? ☐ No ☐ Yes

5. Past Hospitalizations: *Please list any past hospitalizations*

Year _____ Why _____ Hospital _____
Year _____ Why _____ Hospital _____
Year _____ Why _____ Hospital _____

6. Medications: *Please list all current medications*

Medication	Dose	Times per day	Refill Needed (Y/N)?

7. Allergies: *List medications you are allergic to and describe reaction.*

_____
_____

8. Family History: What diseases are common in our family? *Please check all that apply and list affected family member (i.e. mother, father, siblings, grandparents, aunts/uncles, etc)*

☐ Diabetes	☐ Osteoporosis/Osteopenia	☐ Cancer
☐ High Blood Pressure	☐ Stroke / Mini Stroke	☐ Kidney Stones
☐ High Cholesterol	☐ Asthma	☐ Thyroid Problems
☐ Heart Attack	☐ Lung Disease	☐ Other

9. Social History:

Are you married? ☐ No ☐ Yes
Do you have children? ☐ No ☐ Yes
Smoking status: ☐ Current ☐ Former ☐ Daily ☐ Some Days
Year started: _____ Quit: _____ Packs/Day: _____
Alcohol Use: ☐ Never ☐ Socially ☐ Daily ☐ Quit Drinking
Drinks per day: _____ Per week: _____
Caffeine Use: ☐ Rare ☐ Sometimes ☐ Heavy
Drug Use: ☐ No ☐ Yes ☐ Former Type: ☐ Marijuana ☐ Cocaine ☐ Heroin ☐ Other
Exercise: ☐ Never ☐ Some Days ☐ Most Days ☐ Daily

Initial Review of Symptoms

Today's Date _____
Name _____
Date of Birth _____
MR# _____

General

- ☐ Appetite Decreased
- ☐ Appetite Increased
- ☐ Excessive Sweating
- ☐ Fatigue
- ☐ Weight Gain
- ☐ Weight Loss
- ☐ Fever
- ☐ Chills

Eyes

- ☐ Eyes Bulging
- ☐ Eye Irritation
- ☐ Eye Pain
- ☐ Blurred Vision
- ☐ Double Vision
- ☐ Vision Loss – 1 eye
- ☐ Vision Loss – Both eyes
- ☐ Peripheral Vision Loss
- ☐ Tearing
- ☐ Burning
- ☐ Redness
- ☐ Changes in Vision

ENT

- ☐ Decreased Hearing
- ☐ Difficulty Swallowing
- ☐ Epistaxis (nose bleed)
- ☐ Hoarseness
- ☐ Nasal Congestion
- ☐ Neck Masses
- ☐ Sore Throat
- ☐ Tinnitus (ringing)
- ☐ Headache
- ☐ Change in Voice
- ☐ Trouble Chewing

Cardiovascular

- ☐ Bluish Discoloration of Lips or Nails
- ☐ Chest Pain/Discomfort
- ☐ Difficulty Breathing at Night
- ☐ Difficulty Breathing while Laying Down
- ☐ Fainting
- ☐ Leg Cramps with Exertion
- ☐ Lightheadedness
- ☐ Palpitations
- ☐ Racing/Skipping Heart Beat
- ☐ Shortness of Breath with Exertion
- ☐ Swelling of Hands or Feet
- ☐ Leg/Foot Ulcers
- ☐ History of Heart Failure

Allergies

- ☐ Hives or Rash
- ☐ Persistent Infections
- ☐ Seasonal Allergies

Respiratory

- ☐ Cough
- ☐ Coughing Up Blood
- ☐ Shortness of Breath
- ☐ Excessive Snoring
- ☐ Sleep Disturbances due to Breathing
- ☐ Wheezing
- ☐ History of Asthma
- ☐ History of Tuberculosis
- ☐ History of Frequent Colds

GI

- ☐ Abdominal Pain
- ☐ Abdominal Bloating
- ☐ Acid Reflux/Indigestion (heartburn)
- ☐ Constipation
- ☐ Diarrhea
- ☐ Gas
- ☐ Nausea
- ☐ Yellow Skin Color
- ☐ Vomiting
- ☐ Trouble Swallowing
- ☐ Incontinence of Stool
- ☐ Bloody or Dark Black Stool
- ☐ Abdominal Pain

GU

- ☐ Decreased Libido
- ☐ Difficulty Attaining Erection
- ☐ Difficulty Maintaining Erection
- ☐ Difficulty Starting Urination
- ☐ Burning or Pain with Urination
- ☐ Blood in Urine
- ☐ Frequent Urination
- ☐ Urination at Night
- ☐ Incontinence of Urine
- ☐ Genital Discharge
- ☐ Heavy Menstrual Periods
- ☐ History of Kidney Stones
- ☐ History of Hernia

Age of initial Menstrual Period _____

Age of Menopause _____

MS

- ☐ Arthritis
- ☐ Back Pain
- ☐ Joint Pain
- ☐ Joint Swelling
- ☐ Loss of Strength
- ☐ Muscle Aches
- ☐ Muscle Cramps
- ☐ Muscle Mass Increased
- ☐ Muscle Weakness
- ☐ Stiffness
- ☐ Bone Pain
- ☐ History of Fractures?

If so, where & when?

_____

Skin (Derm)

- ☐ Changes in Color of Skin
- ☐ Dryness
- ☐ Darkening of Scars
- ☐ Flushing
- ☐ Night Sweats
- ☐ Purple or Pink Stretch Marks
- ☐ Poor Wound Healing
- ☐ Rash
- ☐ Unusual Hair Distribution
- ☐ Acne
- ☐ Hair Loss
- ☐ Itching
- ☐ Easy Bruising/Bleeding

Neurological

- ☐ Burning/Electrical Pain
- ☐ Difficulty with Concentration
- ☐ Disturbance in Coordination
- ☐ Falling Down
- ☐ Fainting
- ☐ Headaches
- ☐ Numbness
- ☐ Poor Balance
- ☐ Seizures
- ☐ Sensation of Spinning
- ☐ Tingling
- ☐ Tremors
- ☐ Weakness
- ☐ Memory Loss
- ☐ Insomnia

Psychological

- ☐ Anxiety
- ☐ Depression
- ☐ Frightening Visions or Sound
- ☐ Mental Problems
- ☐ Thoughts of Suicide
- ☐ Thoughts of Violence
- ☐ Mood Swings
- ☐ Inability to Enjoy your Favorite Activities

Endocrine

- ☐ Excessive Hunger
- ☐ Excessive Thirst
- ☐ Excessive Urination
- ☐ Intolerance to Cold
- ☐ Intolerance to Heat

Hematology

- ☐ Abnormal Bruising
- ☐ Bleeding
- ☐ Enlarged Lymph Nodes
- ☐ Skin Discoloration
- ☐ HIV Exposure