Today's Date ____________________ MRN ________________________

New Patient Health History

In order to obtain a comprehensive evaluation of your health, your doctor asks that you carefully complete each question.

Name ____ **Birthdate**________________

Who referred you to our practice? ____

Drug Allergies (please list specific reaction to each, especially if life-threatening)

____

Medications (List all including vitamins and supplement with doses and frequency of each – may attach lit if desired.)

______________________ ______________________ ______________________

______________________ ______________________ ______________________

______________________ ______________________ ______________________

______________________ ______________________ ______________________

Pharmacy name and address

____

Specialist Seen

____

Medical Problems (list every medical problem that you have including high cholesterol, diabetes, high blood pressure, abnormal pap smear, cancer, lung/heart/stomach/kidney/liver disease, & psychiatric disorders- **include year of onset for each**)

______________________ ______________________ ______________________

______________________ ______________________ ______________________

______________________ ______________________ ______________________

Past Surgeries (Ex: tonsils, appendix, gallbladder, cataracts, stents, breast biopsy, tubes tied, plastic surgery, prostate)

______________________ ______________________ ______________________

______________________ ______________________ ______________________

______________________ ______________________ ______________________

Family History: Living? Age/Age at Death? Health Problems/Cause of Death (Ex: Heart Attack, Cancer, Stroke, Diabetes, Hypertension)

Mother____

Father ____

Brother ____

Sister ____

M Grandmother ____

M Grandfather ____

P Grandmother ____

P Grandfather ____

Please list any illnesses that are prominent in other family members ____________________________

Today's Date ___________________ MRN ______________________

Social History: **Tobacco Use** (circle one) Current / Quit / Never Start Date _____________ Quit Date __________

Type ________________________ Quantity ________ per day / week Smokeless Y / N _______ cans/day

Alcohol Use (circle one) Y / N Type of Alcohol __________________ Average number of drinks per week ______________

Have you ever or do you currently use illegal drugs? Y / N Type ____

Sexually Active Yes / No / Not Currently Birth Control/Protection Type ____

Marital Status (circle one) Single / Married / Partnered / Divorced / Separated / Widowed

# of Children: ___________ Occupation: _______________________________

Health Maintenance:

Exercise - Do you exercise at all? Y / N If yes how many times per week? ________ Type ________________________

Last colonoscopy __________________________ Normal / Abnormal Next due______________

Last Tetanus vaccine __________________________ TDaP (with whooping cough) or plain TD

Last Pneumonia vaccine _______________________ Pneumovax 23 / Prevnar 13 Last Shingles _____________________

Last Flu vaccine ____________________________ Last Dexa/Bone Density ____________________________

Women Only:

Last Pap smear _________________ Normal / Abnormal Last mammogram _________________ Normal / Abnormal

Men Only:

Last PSA _____________________ Normal / Abnormal

Do you have an Advanced Directive? ____

Please check symptoms that apply to you currently or on a chronic basis.

Name **Date of Birth** **MRN #**

General Symptoms	Yes	No
Activity Change		
Appetite Change		
Chills		
Chronic Pain		
Daytime sleepiness		
Sweating		
Fatigue		
Fever		
Unexpected Weight Change		
HENT		
Congestion		
Dental problem		
Drooling		
Ear discharge		
Ear pain or Facial swelling		
Hearing loss		
Mouth sores		
Nosebleeds		
Postnasal drip		
Reflux		
Runny nose		
Sinus pain		
Sinus pressure		
Sneezing		
Snoring		
Sore throat		
Ringing in ears		
Trouble swallowing		
Voice change		
Eyes		
Eye Discharge		
Eye itching		
Eye pain		
Eye redness		
Light Sensitive		
Visual Disturbance		
Respiratory		
Apnea		
Chest tightness		
Choking		
Cough		
Shortness of breath		
Stridor		
Wheezing		

Cardiovascular	Yes	No
Chest pain		
Leg Swelling		
Palpitations		
GI		
Abdominal Distention		
Abdominal pain		
Rectal bleeding		
Blood in stool		
Bowel incontinence		
Constipation		
Diarrhea		
Nausea		
Rectal pain		
Vomiting		
Endocrine		
Cold intolerance		
Heat intolerance		
Excessive thirst		
Frequent hunger		
Frequent urination		
GU		
Bladder incontinence		
Breast lump		
Decreased libido		
Difficulty urinating		
Painful intercourse		
Painful urination		
Flank pain		
Frequency		
Genital Sore		
Blood in urine		
Wake up at night to urinate		
Sexual difficulties		
Urgency		
Urine decreased		
MEN ONLY		
Erectile dysfunction		
Penile discharge		
Penile pain		
Penile swelling		
Scrotal swelling		
Testicular pain		
FEMALE ONLY		
Menstrual change		
Menstrual problem		
Pelvic pain		
Vaginal bleeding		
Vaginal discharge		
Vaginal pain		

Musculature	Yes	No
Joint pain		
Back pain		
Gait problem		
Joint swelling		
Muscle pain		
Neck pain		
Neck stiffness		
Skin		
Color change		
Hair change		
Hair loss		
Nail change		
Pale appearance		
Rash		
Skin change		
Skin lesion		
Wound		
Allergy/Immuno		
Environmental allergies		
Food allergies		
Immunocompromised		
Neurological		
Dizziness		
Facial asymetry		
Headaches		
Light-headedness		
Numbness		
Seizures		
Speech difficulty		
Syncope (pass out)		
Tremors		
Weakness		
Hematologic		
Enlarged lymph nodes		
Bruise easily		
Psychiatric		
Agitation		
Behavior problem		
Confusion		
Decreased concentration		
Depressed mood		
Uneasy mood		
Hallucinations		
Hyperactive		
Nervous/anxious		
Self-injury		
Severe stress		
Sleep disturbance		
Suicidal ideas		