NEW PATIENT HISTORY FORM

Name_____ **Ht:**_____ **Wt:**_____ **Temp:**_____

Date_____ **B/P:**_____/_____ **Pulse:**_____

CHIEF COMPLAINT:_____

HISTORY OF PRESENT ILLNESS

Location_____
(where is the pain/problem?)

Quality_____
(example: color of sputum)

Severity_____
(How severe is the pain/problem?)

Duration_____
(How long have you had this pain/problem?)

Timing_____
(Does this pain/problem occur at a specific time?)

Context_____
(Where were you at the onset of this pain/problem?)

Associated Signs/Symptoms_____
(What other associated problems have you been having?)

Modifying factors_____
(What makes the pain/problem worse/ better? Previous episodes?)

PATIENT MEDICAL HISTORY:

Diabetes……	**No**	**Yes**	**Previous Hospitalizations/Surgeries/Serious Injuries** **When?**
Hypertension……	**No**	**Yes**	_____
Cancer……...	**No**	**Yes**	_____
Stroke……	**No**	**Yes**	_____
Heart trouble or murmer…	**No**	**Yes**	_____
Arthritis/Gout……..	**No**	**Yes**	_____
Convulsions……..	**No**	**Yes**	
Bleeding tendency……...	**No**	**Yes**	**Medications**
Acute Infections……...	**No**	**Yes**	_____
Venereal disease……..…...	**No**	**Yes**	_____
Hereditary defects……..…..	**No**	**Yes**	_____

PATIENT SOCIAL HISTORY

Marital status: ____Single ____Married ____Separated ____Divorced ____Widowed
Use of alcohol: ____Never ____Rarely ____Moderate ____Daily
Use of tobacco: ____Never ____Previously/quit _____Current pack/day
Use of drugs: ____Never **Type/Frequency**_____
Excessive exposure at work or home to: ____Fumes ____Dust ____Solvent ____Air-born particles ____Noise

FAMILY HISTORY – Has anyone in your immediate family ever had:

___Colon Cancer ___Colon Polyps ___Crohns/Colitis ___Irritable Bowel Syndrome ___Diverticulosis

	Age Living	Age at Death	Cause of death
Father	_____	_____	_____
Mother	_____	_____	_____
Spouse	_____	_____	_____

	Age Living	Age at Death	Cause of death
Siblings	_____	_____	_____
	_____	_____	_____
	_____	_____	_____

DATE REVIEWED/UPDATED_____

SYSTEM REVIEW

CONSITUTIONAL SYMPTOMS

Good general health lately……	No	Yes
Recent weight change……	No	Yes
Fever……	No	Yes
Fatigue…….	No	Yes
Headaches……	No	Yes

EYES

Eye disease or injury…….	No	Yes
Wear glasses/contact lenses……..	No	Yes
Blurred or double vision……...	No	Yes
Glaucoma……	No	Yes

EARS/NOSE/MOUTH/THROAT

Hearing loss or ringing…….	No	Yes
Earaches or drainage……	No	Yes
Chronic sinus problem or rhinitis……..	No	Yes
Nose bleeds……	No	Yes
Mouth sores……...	No	Yes
Bleeding gums……...	No	Yes
Bad breath or bad taste……	No	Yes
Sore throat or voice change…….	No	Yes
Swollen glands in neck…….	No	Yes

CARDIOVASCULAR

Heart trouble or murmur……	No	Yes
Chest pain or angina pectoris……	No	Yes
Palpitation…….	No	Yes
Shortness of breath walking or lying flat..	No	Yes
Swelling of feet, angles or hands……	No	Yes

RESPIRATORY

Chronic or frequent coughs……	No	Yes
Spitting up blood……...	No	Yes
Shortness of breath……..	No	Yes
Asthma or wheezing……	No	Yes

GASTROINTESTINAL

Loss of appetite…….	No	Yes
Change in bowel movements……..	No	Yes
Nausea or Vomiting…….	No	Yes
Frequent diarrhea……	No	Yes
Painful bowel movements or constipation.	No	Yes
Rectal bleeding or blood in stool……	No	Yes
Abdominal pain or heartburn……	No	Yes
Peptic ulcer (stomach or duodenal)……..	No	Yes

GENITOURINARY

Frequent Urination……	No	Yes
Burning or painful urination…….	No	Yes
Blood in urine……...	No	Yes
Change in force of strain when urinating	No	Yes
Incontinence or dribbling……..	No	Yes
Kidney stones…….	No	Yes
Sexual difficulty……..	No	Yes
Male – testicle pain…….	No	Yes
Female – pain with periods…….…...	No	Yes
Female – irregular periods……...	No	Yes
Female – vaginal discharge……..	No	Yes

Female - # of pregnancies_____ # of miscarriages_____

Female – date of last pap smear_____

MUSCULOSKELETAL

Joint Pain……..	No	Yes
Joint stiffness or swelling……	No	Yes
Weakness of muscles or joints…	No	Yes
Back pain……..	No	Yes
Cold extremities……..	No	Yes
Difficulty in walking……	No	Yes
Muscle pain or cramps……	No	Yes

INTEGUMENTARY (SKIN, BREAST)

Rash or itching…….	No	Yes
Change in skin color……	No	Yes
Change in hair or nails……	No	Yes
Varicose veins……	No	Yes
Breast pain……	No	Yes
Breast lump……...	No	Yes
Breast discharge……	No	Yes

NEUROLOGICAL

Frequent or recurring headaches.	No	Yes
Light headed or dizzy……	No	Yes
Convulsions or seizures…….	No	Yes
Numbness or tingling sensations..	No	Yes
Tremors……..	No	Yes
Paralysis…….	No	Yes
Stroke…….	No	Yes
Head Injury……	No	Yes

PSYCHIATRIC

Memory loss or confusion…….	No	Yes
Nervousness……	No	Yes
Depression……...	No	Yes
Insomnia……..	No	Yes

ENDOCRINE

Glandular or hormone problem…	No	Yes
Thyroid disease……	No	Yes
Diabetes…….	No	Yes
Excessive thirst or urination……..	No	Yes
Heat or cold intolerance……..	No	Yes
Skin becoming dryer……	No	Yes
Change in hat or glove size…….	No	Yes

HEMATOLOGIC/LYMPHATIC

Slow to heal after cuts……..	No	Yes
Bleeding or bruising…….	No	Yes
Anemia……...	No	Yes
Phlebitis……..	No	Yes
Past transfusion…….	No	Yes
Enlarged glands……	No	Yes
Hepatitis A B C……	No	Yes

ALLERGIC/IMMUNOLOGIC

History of skin reaction or other adverse reaction to:

Penicillin or other antibiotics…...	No	Yes
Morphine, Demerol or other narcotics	No	Yes
Novocaine or other anesthetics…	No	Yes
Aspirin or other pain remedies…	No	Yes
Tetanus antitoxin or other serums	No	Yes
Iodine, Methiolate or other antiseptic	No	Yes

Other drugs/medications_____

PATIENT INFORMATION

Last Name First Middle Age Birthdate

Sex: M F Marital Status: ___single ___married ___divorced ___widowed

Social Security #

Address City/State/Zip

Occupation/Employer Home phone Business/Cell phone

Emergency contact Phone Relationship

Medication allergies

Referred by

INSURANCE INFORMATION

Insurance Co. Name Group # Contract #

Insurance Address City/State/Zip

Policy holder's Last Name First Middle Birthdate Relationship to patient

Address City/State/Zip

Occupation/Employer Home phone Business/Cell phone