

# Welcome to Our Practice

As a new patient, please fill out the information found below to the best of your ability.

Patient # \_\_\_\_\_ Physician \_\_\_\_\_ Date \_\_\_\_\_

Patient name \_\_\_\_\_ Chief complaint \_\_\_\_\_

## History of Present Illness:

<b>Location</b> (Where is the pain/problem?)	<b>Quality</b> (Example: normal versus abnormal color, activity, etc.)
<b>Severity</b> (How severe is the pain/problem on a scale of 1-5 [5 being the most severe])	<b>Duration</b> (How long have you had this pain/problem, or when did it start?)
<b>Timing</b> (Does this pain/problem occur at a specific time?)	<b>Context</b> (Where were you at the onset of this pain/problem?)
<b>Associated Signs/Symptoms</b> (What other associated problems have you been having?)	<b>Modifying Factors</b> (What makes the pain/problem worse or better? Have you had previous episodes?)

## Patient Medical History:

Have you ever had the following (check "no" or "yes", leave blank if uncertain):

Measles <input type="checkbox"/> No <input type="checkbox"/> Yes	Venereal Disease <input type="checkbox"/> No <input type="checkbox"/> Yes	Blood or Plasma Transfusions <input type="checkbox"/> No <input type="checkbox"/> Yes	Persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks) <input type="checkbox"/> No <input type="checkbox"/> Yes
Mumps <input type="checkbox"/> No <input type="checkbox"/> Yes	Anemia <input type="checkbox"/> No <input type="checkbox"/> Yes	Back Trouble <input type="checkbox"/> No <input type="checkbox"/> Yes	Mitral Valve Prolapse <input type="checkbox"/> No <input type="checkbox"/> Yes
Chickenpox <input type="checkbox"/> No <input type="checkbox"/> Yes	Bladder Infections <input type="checkbox"/> No <input type="checkbox"/> Yes	High or Low Blood Pressure <input type="checkbox"/> No <input type="checkbox"/> Yes	Stroke <input type="checkbox"/> No <input type="checkbox"/> Yes
Whooping Cough <input type="checkbox"/> No <input type="checkbox"/> Yes	Epilepsy <input type="checkbox"/> No <input type="checkbox"/> Yes	Hemorrhoids <input type="checkbox"/> No <input type="checkbox"/> Yes	Hepatitis <input type="checkbox"/> No <input type="checkbox"/> Yes
Scarlet Fever <input type="checkbox"/> No <input type="checkbox"/> Yes	Migraine Headaches <input type="checkbox"/> No <input type="checkbox"/> Yes	Asthma <input type="checkbox"/> No <input type="checkbox"/> Yes	Ulcer <input type="checkbox"/> No <input type="checkbox"/> Yes
Diphtheria <input type="checkbox"/> No <input type="checkbox"/> Yes	Tuberculosis <input type="checkbox"/> No <input type="checkbox"/> Yes	Hives or Eczema <input type="checkbox"/> No <input type="checkbox"/> Yes	Kidney Disease <input type="checkbox"/> No <input type="checkbox"/> Yes
Smallpox <input type="checkbox"/> No <input type="checkbox"/> Yes	Diabetes <input type="checkbox"/> No <input type="checkbox"/> Yes	AIDS or HIV+ <input type="checkbox"/> No <input type="checkbox"/> Yes	Thyroid Disease <input type="checkbox"/> No <input type="checkbox"/> Yes
Pneumonia <input type="checkbox"/> No <input type="checkbox"/> Yes	Cancer <input type="checkbox"/> No <input type="checkbox"/> Yes	Infectious Mono <input type="checkbox"/> No <input type="checkbox"/> Yes	Bleeding Tendency <input type="checkbox"/> No <input type="checkbox"/> Yes
Rheumatic Fever <input type="checkbox"/> No <input type="checkbox"/> Yes	Polio <input type="checkbox"/> No <input type="checkbox"/> Yes	Bronchitis <input type="checkbox"/> No <input type="checkbox"/> Yes	Any Other Disease (please list) <input type="checkbox"/> No <input type="checkbox"/> Yes
Heart Disease <input type="checkbox"/> No <input type="checkbox"/> Yes	Glaucoma <input type="checkbox"/> No <input type="checkbox"/> Yes	Date of last chest x-ray: _____	
Arthritis <input type="checkbox"/> No <input type="checkbox"/> Yes	Hernia <input type="checkbox"/> No <input type="checkbox"/> Yes		

Previous Hospitalizations/Surgeries/Serious Illnesses	When	Hospital, City, State/Prov.
_____	_____	_____
_____	_____	_____
_____	_____	_____

**Medications** (include nonprescription):

Have you ever taken Fen-Phen/Redux?  No  Yes

## Patient Social History:

Marital status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed
Use of alcohol: <input type="checkbox"/> Never <input type="checkbox"/> Rarely <input type="checkbox"/> Moderate <input type="checkbox"/> Daily
Use of tobacco: <input type="checkbox"/> Never <input type="checkbox"/> Previously, but quit: _____ <input type="checkbox"/> Current packs/day _____
Use of drugs: <input type="checkbox"/> Never <input type="checkbox"/> Type/frequency: _____
Excessive exposure at home or work to: <input type="checkbox"/> Fumes <input type="checkbox"/> Dust <input type="checkbox"/> Solvents <input type="checkbox"/> Airborne particles <input type="checkbox"/> Noise

## Family Medical History:

	Age	Diseases	If deceased, cause of death
Father	_____	_____	_____
Mother	_____	_____	_____
Siblings	_____	_____	_____
Spouse	_____	_____	_____
Children	_____	_____	_____

## Review of Systems: Please indicate any personal history below.

### CONSTITUTIONAL 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

### EARS/NOSE/MOUTH/THROAT

- Hearing loss or ringing  No  Yes  
 Earaches or drainage  No  Yes  
 Chronic sinus problems 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  No  Yes  
 Chest pain or angina pectoris  No  Yes  
 Palpitation  No  Yes  
 Shortness of breath walking or lying flat  No  Yes  
 Swelling of feet, ankles or hands  No  Yes

### RESPIRATORY

- Chronic or frequent coughs  No  Yes  
 Spitting up blood  No  Yes  
 Shortness of breath  No  Yes  
 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  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: \_\_\_\_\_  
 Female - # 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  
 Muscle pain or cramps  No  Yes  
 Back pain  No  Yes  
 Cold extremities  No  Yes  
 Difficulty in walking  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  
 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  
 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 tendency  No  Yes  
 Anemia  No  Yes  
 Phlebitis  No  Yes  
 Past transfusion  No  Yes  
 Enlarged glands  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  
 Novocain or other anesthetics  No  Yes  
 Aspirin or other pain remedies  No  Yes  
 Tetanus antitoxin or other serums  No  Yes  
 Iodine, merthiolate or other antiseptics  No  Yes

Other drugs/medications: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Known food allergies: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Environmental allergies: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

### AUTHORIZATION & RELEASE

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my respon to inform the doctor's office of any changes in my medical status. I also authorize the healthcare staff to perform the necessary services I may need.

X \_\_\_\_\_

Signature of patient (or parent/guardian if minor)

\_\_\_\_\_ Date

Doctor's Review: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_