



Welcome to Our Practice

As a new patient, please fill out the information found below to the best of your ability **(front and back)**

Today's Date _____

Patient name _____ Age _____ Sex (circle) M F

Reason for your visit _____

Referring Physician _____ Address _____

Patient Medical History

Have you ever had the following ("check" those which apply to you)

List any other diseases

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Major Infection |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Asthma | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Seizures | <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Migraine Headaches | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> HIV |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Back Trouble | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Polio | <input type="checkbox"/> Ulcers | <input type="checkbox"/> None of the above |

Previous hospitalizations/ Surgeries/ Serious Illnesses

Please list all of your current medications and doses
(Include all vitamins, supplements and over the counter medications)

List all allergies

_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Patient Social History

Occupation _____	Are you retired? yes no
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"/> No <input type="checkbox"/> Previously but quit	<input type="checkbox"/> Yes - Amount? _____
Use of tobacco <input type="checkbox"/> No <input type="checkbox"/> Previously but quit	<input type="checkbox"/> Yes - packs/day _____
Use of "recreational" drugs <input type="checkbox"/> No <input type="checkbox"/> Previously but quit	<input type="checkbox"/> Yes - What? _____

Family Medical History

Current Age	Any Chronic Illnesses or Diseases	If deceased, cause of death
Father _____	_____	_____
Mother _____	_____	_____
Brothers & sisters _____	_____	_____
_____	_____	_____
Children _____	_____	_____
_____	_____	_____
_____	_____	_____

Review of Systems

Please indicate if any of these apply to you over the last 3 months

<p>Constitutional</p> <input type="checkbox"/> Recent weight change <input type="checkbox"/> Loss of appetite <input type="checkbox"/> Fatigue <input type="checkbox"/> Insomnia <input type="checkbox"/> Fever	<p>Cardiovascular</p> <input type="checkbox"/> Heart trouble <input type="checkbox"/> Chest pain <input type="checkbox"/> Heart murmur <input type="checkbox"/> Palpitations <input type="checkbox"/> Varicose veins <input type="checkbox"/> Swelling of the feet or ankles	<p>Gastrointestinal</p> <input type="checkbox"/> Nausea <input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation <input type="checkbox"/> Abdominal pain <input type="checkbox"/> Blood in the stool	<p>Neurological</p> <input type="checkbox"/> Frequent headaches <input type="checkbox"/> Light headed or dizzy <input type="checkbox"/> Convulsions or seizures <input type="checkbox"/> Numbness or tingling sensation <input type="checkbox"/> Tremors <input type="checkbox"/> Paralysis <input type="checkbox"/> Head injury
<p>Eyes</p> <input type="checkbox"/> Eye disease <input type="checkbox"/> Glasses or contacts <input type="checkbox"/> Blurred or double vision <input type="checkbox"/> Vision loss	<p>Respiratory</p> <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Chronic cough <input type="checkbox"/> Wheezing	<p>Genitourinary</p> <input type="checkbox"/> Frequent urination <input type="checkbox"/> Urgency of urination <input type="checkbox"/> Painful urination <input type="checkbox"/> Incontinence <input type="checkbox"/> Sexual difficulty <input type="checkbox"/> Kidney stones	<input type="checkbox"/> Memory loss <input type="checkbox"/> Fainting <input type="checkbox"/> Poor balance <input type="checkbox"/>
<p>Ears/Nose/Mouth/Throat</p> <input type="checkbox"/> Hearing loss <input type="checkbox"/> Ringing in the ears <input type="checkbox"/> Sinus problems <input type="checkbox"/> Nose bleeds <input type="checkbox"/> Mouth sores <input type="checkbox"/> Swollen glands in the neck	<p>Hematological</p> <input type="checkbox"/> Bleeding tendency <input type="checkbox"/> Anemia <input type="checkbox"/> Recurrent infections	<p>Musculoskeletal</p> <input type="checkbox"/> Joint pain <input type="checkbox"/> Joint swelling <input type="checkbox"/> Weakness of muscles or joints <input type="checkbox"/> Muscle pain or cramps <input type="checkbox"/> Back pain <input type="checkbox"/> Difficulty walking	<p>Psychiatric</p> <input type="checkbox"/> Nervousness <input type="checkbox"/> Depression <input type="checkbox"/> Hallucinations
	<p>Endocrine</p> <input type="checkbox"/> Excessive thirst <input type="checkbox"/> Heat or cold intolerance <input type="checkbox"/> Glandular or hormone problems		<p>Skin</p> <input type="checkbox"/> Rash or itching <input type="checkbox"/> Change in skin color <input type="checkbox"/> Change in hair or nails

None of the above

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 responsibility 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 if minor) _____
Date

Doctor's Review _____

X _____
 Signature of Doctor _____
Date