NEW PATIENT FORM

Name: _____

Date of Birth: _____

What problems brought you to the office today? _____

Marital Status: _____ Who do you live with: _____

Occupation: _____ Tobacco: ☐ Yes _____PPD ☐ Never Smoked ☐ Former Smoker

Caffeine: ☐ Coffee ☐ Tea ☐ Soda ☐ More than 2 servings/day ☐ Less than 2 servings/day

Alcohol: ☐ None ☐ Daily ☐ Weekly ☐ Socially Only ☐ Rarely ☐ Drinks Alone

Other Substances / Recreational Drugs: ☐ Yes ☐ No _____

PAST MEDICAL HISTORY (please answer all questions with YES or NO)

Asthma:	☐ Yes ☐ No	Endometriosis:	☐ Yes ☐ No	Thyroid Disease:	☐ Yes ☐ No
High Blood Pressure:	☐ Yes ☐ No	Anemia:	☐ Yes ☐ No	Abnormal Pap Smears:	☐ Yes ☐ No
Stroke/TIA	☐ Yes ☐ No	Back Injury	☐ Yes ☐ No	Migraines	☐ Yes ☐ No
Diabetes:	☐ Yes ☐ No	Kidney Disease/Stones:	☐ Yes ☐ No	Sexually Transmitted Infections:	☐ Yes ☐ No

Additional: _____

PAST SURGICAL HISTORY (please list and give dates) _____

_____

REVIEW OF SYSTEMS (please answer all questions with YES or NO if you have experienced these symptoms recently**}**

Constitutional
Weakness: ☐ Yes ☐ No
Chills ☐ Yes ☐ No
Fever ☐ Yes ☐ No
Weight Change ☐ Yes ☐ No

Gynecologic
Heavy Menses ☐ Yes ☐ No
Irregular Menses ☐ Yes ☐ No
Painful Intercourse ☐ Yes ☐ No
Pelvic Pain ☐ Yes ☐ No
Hot Flashes ☐ Yes ☐ No

Genitourinary
Frequent UTI ☐ Yes ☐ No
Painful Urination ☐ Yes ☐ No
Blood in Urine ☐ Yes ☐ No
Urinary Leakage ☐ Yes ☐ No
Urinary Urgency ☐ Yes ☐ No
Waking>1 to Urinate ☐ Yes ☐ No

Gastrointestinal
Diarrhea ☐ Yes ☐ No
Constipation ☐ Yes ☐ No
Heartburn ☐ Yes ☐ No
Bowel/Gas Leakage ☐ Yes ☐ No

Eyes
Glasses/Contacts ☐ Yes ☐ No
Double Vision ☐ Yes ☐ No
Blurry Vision ☐ Yes ☐ No

Ear, Nose, Throat
Hearing Change ☐ Yes ☐ No
Sore Throat ☐ Yes ☐ No
Sinus Pain ☐ Yes ☐ No

Psychiatric
Depression ☐ Yes ☐ No
Mood Changes ☐ Yes ☐ No
Anxiety ☐ Yes ☐ No

Hematologic
Bleeding ☐ Yes ☐ No
Bruising ☐ Yes ☐ No

Respiratory
Shortness of Breath ☐ Yes ☐ No
Coughing Blood ☐ Yes ☐ No
Wheezing ☐ Yes ☐ No
Nose Bleeds ☐ Yes ☐ No

Cardiac
Chest Pain ☐ Yes ☐ No
Swelling ☐ Yes ☐ No
Irregular Heart Beat ☐ Yes ☐ No

Neurologic
Headaches ☐ Yes ☐ No
Fainting Spells ☐ Yes ☐ No
Memory Loss ☐ Yes ☐ No
Numbness/tingling ☐ Yes ☐ No

Skin
Rash ☐ Yes ☐ No
Hair growth/loss ☐ Yes ☐ No
Pigment Changes ☐ Yes ☐ No

Musculoskeletal
Joint Pain ☐ Yes ☐ No
Muscle Weakness ☐ Yes ☐ No
Unsteady Gait ☐ Yes ☐ No

Breast
Breast Lump ☐ Yes ☐ No
Breast Pain ☐ Yes ☐ No
Nipple Discharge ☐ Yes ☐ No

Endocrine
Heat/Cold Intolerant ☐ Yes ☐ No
Excessive Thirst ☐ Yes ☐ No
Increased Urination ☐ Yes ☐ No

FAMILY HISTORY (please answer all questions with YES or NO)

Father: ☐ Deceased ☐ Diabetes ☐ High Blood Pressure ☐ Heart Disease ☐ Stroke ☐ Mental Illness ☐ Cancer ☐ Osteoporosis
Mother: ☐ Deceased ☐ Diabetes ☐ High Blood Pressure ☐ Heart Disease ☐ Stroke ☐ Mental Illness ☐ Cancer ☐ Osteoporosis
Brother(s): ☐ Deceased ☐ Diabetes ☐ High Blood Pressure ☐ Heart Disease ☐ Stroke ☐ Mental Illness ☐ Cancer ☐ Osteoporosis
Sister(s): ☐ Deceased ☐ Diabetes ☐ High Blood Pressure ☐ Heart Disease ☐ Stroke ☐ Mental Illness ☐ Cancer ☐ Osteoporosis
Son(s): ☐ Deceased ☐ Diabetes ☐ High Blood Pressure ☐ Heart Disease ☐ Stroke ☐ Mental Illness ☐ Cancer ☐ Osteoporosis
Daughter(s): ☐ Deceased ☐ Diabetes ☐ High Blood Pressure ☐ Heart Disease ☐ Stroke ☐ Mental Illness ☐ Cancer ☐ Osteoporosis
Paternal Grandfather: ☐ Deceased ☐ Diabetes ☐ High Blood Pressure ☐ Heart Disease ☐ Stroke ☐ Mental Illness ☐ Cancer ☐ Osteoporosis
Paternal Grandmother: ☐ Deceased ☐ Diabetes ☐ High Blood Pressure ☐ Heart Disease ☐ Stroke ☐ Mental Illness ☐ Cancer ☐ Osteoporosis
Maternal Grandfather: ☐ Deceased ☐ Diabetes ☐ High Blood Pressure ☐ Heart Disease ☐ Stroke ☐ Mental Illness ☐ Cancer ☐ Osteoporosis
Maternal Grandfather: ☐ Deceased ☐ Diabetes ☐ High Blood Pressure ☐ Heart Disease ☐ Stroke ☐ Mental Illness ☐ Cancer ☐ Osteoporosis

ADDITIONAL: _____

Patient Signature: _____ Date: _____