

New Patient Information Form

Date: _____
Name: _____
Referred by: _____

FAMILY HISTORY

-Has any blood relative had any of the following:
 -Circle "yes" or "no"-if so what relationship:
 Asthma Yes No _____
 Bleeding tendency Yes No _____
 Cancer Yes No _____
 Diabetes Yes No _____
 Heart disease Yes No _____
 High blood pressure Yes No _____
 Kidney disease Yes No _____
 Tuberculosis Yes No _____

PATIENT SOCIAL HISTORY

Marital Status:
 Single Married Separated Divorced Widowed

Use of Alcohol:
 Never Rarely Moderate Daily

Use of Tobacco:
 Never Previously, but quit Current packs/day _____

Use of Drugs:
 Never Type/Frequency _____

Excessive exposure at home or work to:
 Fumes Dust Solvents Airborne Particles Noise

MEDICAL HISTORY

Previous Hospitalizations/Surgeries/Serious Injuries

_____ When? _____
 _____ When? _____
 _____ When? _____
 _____ When? _____
 _____ When? _____

Medications

1. _____
 2. _____
 3. _____
 4. _____

Allergies

1. _____
 2. _____

PERSONAL PAST HISTORY

Circle "yes" or "no"

HAVE YOU EVER HAD:

Allergies	Yes	No
Anemia	Yes	No
Arthritis	Yes	No
Asthma/lung problems	Yes	No
Back trouble	Yes	No
Bladder disorder	Yes	No
Bleeding tendency	Yes	No
Blood transfusion	Yes	No
Cancer	Yes	No
Diabetes	Yes	No
Gallstones	Yes	No
Heart disease	Yes	No
Heart murmur	Yes	No
Hepatitis	Yes	No
High blood pressure	Yes	No
Kidney disease	Yes	No
Psychiatric disorder	Yes	No
Rheumatic fever	Yes	No
Seizures	Yes	No
Stomach/Bowel problems	Yes	No
Tuberculosis	Yes	No
Exposure to TB	Yes	No
Ulcer	Yes	No
Venereal Disease	Yes	No
Other	Yes	No
_____	Yes	No
_____	Yes	No
_____	Yes	No

Year

OPERATIONS:

Tonsils	Yes	No
Appendix	Yes	No
Gallbladder	Yes	No
Stomach	Yes	No
Breast	Yes	No
Uterus and/or Ovary	Yes	No
Prostate	Yes	No
Hernia	Yes	No
Thyroid	Yes	No
Varicose Veins	Yes	No
Hemorrhoids	Yes	No
Heart	Yes	No
Metal Implants	Yes	No
Other	Yes	No

Year

INJURIES:

Head	Yes	No
Chest/Back	Yes	No
Abdomen	Yes	No
Broken Bones	Yes	No

Year

New Patient Information Form

CONSTITUTIONAL SYMPTOMS

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

EYES

Eye disease or injury Yes No
 Wear glasses/contact lens Yes No
 Blurred or double vision Yes No
 Glaucoma Yes No

EARS/NOSE/MOUTH/THROAT

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

CARDIOVASCULAR

Heart trouble Yes No
 Chest pain or angina pectoris Yes No
 Palpitations Yes No
 Shortness of breath with walking Yes No
 Swelling of feet, ankles, or hands Yes No

REPIRATORY

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

GASTROINTESTINAL

Loss of appetite Yes No
 Change in bowel movements Yes No
 Nausea or vomiting Yes No
 Frequent diarrhea Yes No
 Painful bowel movements/Constipation Yes No
 Rectal bleeding or blood in stool Yes No
 Abdominal pain or heart burn Yes No
 Peptic ulcer (stomach or duodenal) Yes No

GENITOURINARY

Frequent urination Yes No
 Burning or painful urination Yes No
 Blood in urine Yes No
 Incontinence or dribbling Yes No
 Kidney Stones Yes No
 Male-testicle pain Yes No
 Female- pain with periods Yes No
 Female- irregular periods Yes No
 Female- vaginal discharge Yes No
 Female # of pregnancies _____ #miscarries _____
 Female-age of first period _____
 Female- date of last pap smear ___/___/_____
 1st day of last menstrual cycle _____

MUSCULOSKELETAL

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

INTEGUMENTARY

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

NEUROLOGICAL

Frequent or recurring headaches Yes No
 Light headed or dizzy Yes No
 Convulsions or seizures Yes No
 Numbness or tingling sensation Yes No
 Tremors Yes No
 Paralysis Yes No
 Stroke Yes No
 Head injury Yes No

PSYCHIATRIC

Memory loss or confusion Yes No
 Nervousness Yes No
 Depression Yes No
 Insomnia Yes No
 Claustrophobia Yes No

ENDOCRINE

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

HEMATOLOGICAL/LYMPHATIC

Slow to heal after cuts Yes No
 Bleeding or bruising tendency Yes No
 Phlebitis Yes No
 Past transfusion Yes No
 Enlarge glands Yes No

ALLERGIC/IMMUNOLOGIC

History or skin reaction or other adverse reaction to:
 Penicillin or other antibiotics Yes No
 Morphine, Demerol, other narcotics Yes No
 Novocaine or other anesthetic Yes No
 Aspirin or other pain remedies Yes No
 Tetanus antitoxin or other serums Yes No
 Iodine, methiolate or other antiseptic Yes No
 Contrast Yes No
 Other drugs/Medications _____
 Known food allergies _____
 What pain medication has been effective for you? _____