

NEW PATIENT MEDICAL HISTORY

Patient Name: _____

Chief Complaint: _____

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	Mitral Valve Prolapse	<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	Bronchitis	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Chicken Pox	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Bladder infection	<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	Hepatitis	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Scarlet Fever	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Migraine Headache	<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	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	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	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	Blood Transfusions	<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	Plasma Transfusions	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Arthritis	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Hernia	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Back Trouble	<input type="checkbox"/> No	<input type="checkbox"/> Yes
High Blood Pressure	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Hemorrhoids	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Asthma	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Low Blood Pressure	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Hives	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Eczema	<input type="checkbox"/> No	<input type="checkbox"/> Yes
AIDS OR HIVS	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Infectious Mono	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Date of last Chest x-ray:		
Any Other Disease	<input type="checkbox"/> No	<input type="checkbox"/> Yes						
(please list):								

Previous Hospitalizations/ Surgeries/ Serious Illnesses

When

Hospital, City, State

Medications Taken (include nonprescription):

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"/> Currently packs/day:		
Use of Drugs:	<input type="checkbox"/> Never	<input type="checkbox"/> Type/frequency:			
Excessive exposure at home/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			
Siblings			
Spouse			
Children			
Children			

Review of Systems

Please indicate any personal history below:

CONSTITUTIONAL SYMPTOMS			GENITOURINARY		
Good general health lately	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Frequent urination	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Recent weight change	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Burning urination	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Fever	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Painful urination	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Fatigue	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Blood in urine	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Headaches	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Changes in force of strain when urinating	<input type="checkbox"/> No	<input type="checkbox"/> Yes
EYES			Incontinence or dribbling		
Eye disease or injury	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Kidney stones	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Wear glasses	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Sexual difficulty	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Contact Lenses	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Male-testicle pain	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Blurred	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Female-pain with periods	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Double vision	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Female-irregular periods	<input type="checkbox"/> No	<input type="checkbox"/> Yes
EARS/NOSE/MOUTH/THROAT			Female-vaginal discharge		
Hearing loss or ringing	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Female # of pregnancies:		
Earaches or drainage	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Female # of miscarriages::		
Chronic sinus problems	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Female- date of last pap smear:		
Rhinitis	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Female- date of last mammogram:		
Nose bleeds	<input type="checkbox"/> No	<input type="checkbox"/> Yes	MUSCULOSKELETAL		
Mouth sores	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Joint pain	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Bleeding gums	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Joint stiffness or swelling	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Bad breath or bad taste	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Weakness of muscles or joints	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Sore throat or voice change	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Muscle pain or cramps	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Swollen glands in neck	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Back pain	<input type="checkbox"/> No	<input type="checkbox"/> Yes
CARDIOVASCULAR			Cold extremities		
Heart trouble	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Difficulty in walking	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Chest pain	<input type="checkbox"/> No	<input type="checkbox"/> Yes	INTEGUMENTARY (skin, breast)		
Angina pectoris	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Rash or itching	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Palpitation	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Change in skin color	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Shortness of breath walking	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Change in hair or nails	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Shortness of breath lying flat	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Varicose veins	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Swelling of feet/ankles/hands	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Breast pain	<input type="checkbox"/> No	<input type="checkbox"/> Yes
RESPIRATORY			Breast lump		
Chronic/frequent coughs	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Breast discharge	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Spitting up blood	<input type="checkbox"/> No	<input type="checkbox"/> Yes	NEUROLOGICAL		
Shortness of breath	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Frequent or recurring headaches	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Wheezing	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Light headed or dizzy	<input type="checkbox"/> No	<input type="checkbox"/> Yes
GASTROINTESTINAL			Convulsions or seizures		
Loss of appetite	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Numbness or tingling sensation	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Change in bowel movements	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Tremor	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Nausea or vomiting	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Paralysis	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Frequent diarrhea	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Head injury	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Painful bowel movements	<input type="checkbox"/> No	<input type="checkbox"/> Yes	PSYCHIATRIC		
Painful constipation	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Memory loss or confusion	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Rectal bleeding	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Nervousness	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Blood in stool	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Depression	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Abdominal pain	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Insomnia	<input type="checkbox"/> No	<input type="checkbox"/> Yes
ENDOCRINE			HEMATOLOGIC/LYMPHATIC		
Glandular or hormone problem	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Slow to heal after cuts	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Excessive thirst or urination	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Bleeding or bruising tendency	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Heat or cold tolerance	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Anemia	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Skin becoming drying	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Phlebitis	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Change in hat or glove size	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Past transfusion	<input type="checkbox"/> No	<input type="checkbox"/> Yes
ALLERGIC/IMMUNOLOGIC			Enlarged glands	<input type="checkbox"/> No	<input type="checkbox"/> Yes
History of skin reaction	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Other drugs/medication allergies:		
Reaction to penicillin	<input type="checkbox"/> No	<input type="checkbox"/> Yes			
Reaction to antibiotics	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Known food allergies:		
Morphine, Demerol, narcotics	<input type="checkbox"/> No	<input type="checkbox"/> Yes			
Novocain or other anesthetics	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Environmental allergies:		
Aspirin or other pain remedies	<input type="checkbox"/> No	<input type="checkbox"/> Yes			
Tetanus antitoxin or other serum	<input type="checkbox"/> No	<input type="checkbox"/> Yes			
Iodine, methiolate or antiseptics	<input type="checkbox"/> No	<input type="checkbox"/> Yes			

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 authorized the healthcare staff to perform the necessary services I may need.

X _____ X _____
 Print Name Signature of patient (or parent if minor) Date