NEW PATIENT HISTORY

Name: _____

DOB: _____

Why are you here today? _____

Medical History

Problem (e.g. hypertension, diabetes)	Year diagnosed

Surgical History

Surgery	Year Performed	Surgeon

Current Medications

Medication	Dose	How Often	Medication	Dose	How Often

Medication Allergies

Medication	Reaction

Common Problems or Persistent Conditions (circle positives)

Constitutional: Fever Chills Weight Loss Fatigue Sweating Weakness

Skin: Rash Itching

HENT: Hearing loss Tinnitus/ringing ear pain ear discharge nosebleeds Congestion Sinus pain Stridor Sore throat

Eyes: Blurred vision Double vision Light sensitivity Eye Pain Eye Discharge Eye Redness

Cardiovascular: Chest pain Palpitations Orthopnea/Shortness of breath Leg cramps Leg swelling Shortness of Breath at night

Respiratory: Cough Coughing up blood Sputum production Shortness of Breath Wheezing

GI: Heartburn Nausea Vomiting Abdominal pain Diarrhea Constipation Blood in stool Melena

GU: Painful urination Urgency Frequency Hematuria Flank pain

Musculoskeletal: Muscle pain Neck pain back pain Joint pain Falls

Heme/Lymph/Allergies: Easy bruising Enviro Allergies Extreme thirst

Neurological: Dizziness Headaches Tingling Tremor Sensory change Speech change Focal weakness Seizures LOC

Psychiatric: Depression Suicidal Ideas Substance abuse Hallucinations Nervous/Anxious Insomnia Memory Loss

Social History

Single Married Widowed

Do you smoke? Yes/No If yes, how much? _____

Do you drink Alcohol? Yes/No If Yes, How much? _____

Did/Do you use illegal Drugs? Yes/No If Yes, What_____

Family History

Mother: Alive/Deceased Age___ Illness: _____

Father: Alive/Deceased Age___ Illness: _____

Sister: Alive/Deceased Age___ Illness: _____

Brother: Alive/Deceased Age___ Illness: _____

Preferred Pharmacy: _____