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:	weight loss/gain	night sweats	difficulty sleeping	
Eyes, ears:	vision change	blurriness	trouble hearing	
Nose, mouth, throat:	nasal congestion	problems swallowing	mouth sores	
Cardiovascular:	chest pain	palpatations	light headed	
Respiratory:	cough	wheeze	wake at night short of breath	
GI: diarrhea	constipation	blood in stool	heartburn	incontinence
GU:	painful urination	trouble start/stop stream	night-time urination	incontinence
Musculoskeletal:	leg swelling	muscle pain	joint pain	
Skin, breast: rash	masses	abnormal mammogram		
Neuro:	numbness	weakness	tremor	
Psych:	depression	tearfulness	anxiety	mania
Endocrine:	temperature intolerance			
Heme/lymph:	easy bleeding	anemia		
Allergies:	pollens	chemicals	animals	

SOCIAL HISTORY

Single Married Separated

Children (with age) _____

Current/previous occupation: _____

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

Who lives with you? _____

Do you feel safe at home? Yes / No

FAMILY HISTORY

Mother: alive/deceased age:_____ Illness:_____

Father: alive/deceased age:_____ Illness:_____

Brother: alive/deceased age:_____ Illness:_____

Sister: alive/deceased age:_____ Illness:_____

Othe family members: _____