

Name: _____ Date of Birth: _____

Today's Date: _____ Referring Provider/Provider Phone #: _____

New Patient

HISTORY- COMPLETED BY PATIENT, STAFF, OR PROVIDER

Reason for your visit today _____

Please indicate if you are having any current problems, signs or symptoms in any of the following areas:

√ Check box then circle and/or add comments

- General Wellness:* Fatigue, Fever, Chills, Weight Loss or Gain, Sweats, Other: _____
- Neurological:* Weakness, Numbness, Headache, Loss of sleep, Other: _____
- Eyes:* Vision Changes, Redness, Other: _____
- Environmental/Food Allergies:* _____
- Skin:* Rashes, Dryness, Other: _____
- Reproductive/Urinary:* Prostate, Kidney Diseases _____
- Ears, Nose, Throat:* Hoarseness, Loss of hearing, Other: _____
- Endocrine:* **Diabetes**, Thyroid, Last menstrual period _____ Other: _____
- Stomach/Digestion:** Constipation, Diarrhea, Nausea, Vomiting, Swallowing difficulty, Ulcers, Helicobacter pylori, Polyps, Diverticulosis, GI bleeding, Liver disease, Hepatitis, Poor appetite, Heartburn, Bloating, Excessive Hunger, Excessive thirst, Indigestion, Abdominal pain, Vomiting blood, Other GI: _____
- Psychiatric:* Depression, Anxiety, Other: _____
- Lungs/Breathing:* Asthma, Emphysema, Sleep apnea, Oxygen use, Other: _____
- Blood/Lymph:* Anemia, **Blood Thinners:** _____
- Heart/Circulation:* Heart Attacks, Heart Failure, Irregular heart beat, **Pacemaker, Leaky valves**, Other: _____
- Muscles/Joints/Bones:* Arthritis _____
- Other:* Infections, HIV _____

Physician Comments (ROS) All other systems negative _____

ROS: 1 prob. pertinent, 2-9 extended, 10+complete

3. Medication(s) (drugs, pills):

4. Previous Surgeries/Dates:

5. Medication Allergies

6. Social History:

Marital Status: Single; Divorced; Married; Widow/Widower Who lives with you? _____

Current Occupation/Employer _____ What kind of work? _____

Do you smoke? _____ How many packs a day? _____ For how many years? _____

Do you drink alcohol? _____ How many drinks per day? _____ per week? _____ per month? _____

Do you use illicit drugs? _____ If yes, what kind? _____

Could you be pregnant? Yes No

7. Family Illnesses: Colon Cancer/Polyps? Yes, Site? _____ Who? _____ No

Other Cancers? Yes, Type? _____ Who? _____ No

Family History of **Heart Disease** (heart attack, heart failure) **strokes, high blood pressure, diabetes:** Yes No

Who? _____