NEW PATIENT HISTORY FORM

Full Name: _____ AGE:_____ SEX: _____M_____F

Preferred Name (the name you would like us to call you):_____

Primary Care Provider: _____ Who referred you to see us today? _____

Reason for your visit:_____

SOCIAL HISTORY:

Occupation: _____ Employer:_____

Dominant Hand: ____RIGHT _____LEFT

Do you use any tobacco or nicotine-containing products? _____YES _____ NO

If YES, what do you use, how much, and how often? _____

ALLERGIES: *PLEASE CHECK IF YOU HAVE ANY OF THE FOLLOWING:*

( ) None ( ) Contrast/ Dye ( ) Sulfa ( ) Penicillin ( ) Local Anesthetics ( ) Latex ( ) Iodine

( ) Shellfish ( ) Metals (including any history of skin irritation/reaction/color change with cheap jewelry or silver)

( ) Other (please specify) _____

REVIEW OF SYSTEMS *PLEASE CIRCLE YES OR NO IF YOU HAVE ANY OF THE FOLLOWING:*

Constitutional			**Ears/Nose/Mouth/Throat**			**Eyes**		
Good General Health	**Y**	**N**	Hearing loss/ring	**Y**	**N**	Wear glasses/contacts	**Y**	**N**
Recent Weight Change	**Y**	**N**	Sinus Problems	**Y**	**N**	Blurred/double vision	**Y**	**N**
Night Sweats, Fevers	**Y**	**N**	Nose Bleeds	**Y**	**N**	Eye disease or injury	**Y**	**N**
Fatigue	**Y**	**N**	Sore Throat/voice change	**Y**	**N**	Glaucoma	**Y**	**N**
Cardiovascular			**Respiratory**			**Gastrointestinal**		
Chest Pain	**Y**	**N**	Shortness of Breath	**Y**	**N**	Nausea/vomiting	**Y**	**N**
Palpitations	**Y**	**N**	Cough	**Y**	**N**	Abdominal Pain	**Y**	**N**
Heart Problems	**Y**	**N**	Wheezing/Asthma	**Y**	**N**	Rectal bleeding	**Y**	**N**
Swelling hands/feet	**Y**	**N**	Coughing up blood	**Y**	**N**	Bowel problems	**Y**	**N**
Musculoskeletal			**Neurological**			**Integumentary (skin/breast)**		
Muscle Pain or Cramps	**Y**	**N**	Frequent headaches	**Y**	**N**	Change in hair or nails	**Y**	**N**
Stiffness/swelling joints	**Y**	**N**	Paralysis or Tremors	**Y**	**N**	Rashes or itching	**Y**	**N**
Joint Pain	**Y**	**N**	Convulsions/seizures	**Y**	**N**	Breast lumps	**Y**	**N**
Trouble walking	**Y**	**N**	Numbness/tingling	**Y**	**N**	Breast pain or discharge	**Y**	**N**
Endocrine			**Hematologic/Lymphatic**			**Allergic/Immunologic**		
Excessive thirst/urination	**Y**	**N**	Bruise easily	**Y**	**N**	Food/Allergies	**Y**	**N**
Thyroid Disease	**Y**	**N**	Slow to Heal	**Y**	**N**	Aspirin Allergies	**Y**	**N**
Hormone Problems	**Y**	**N**	Enlarged glands	**Y**	**N**	Antibiotic Allergies	**Y**	**N**
Genitourinary – Males			**Genitourinary – Females**			**Psychiatric**		
Blood in Urine	**Y**	**N**	Blood in Urine	**Y**	**N**	Insomnia	**Y**	**N**
Kidney Stones	**Y**	**N**	Kidney Stones	**Y**	**N**	Confusion/memory loss	**Y**	**N**
Sexual Problems	**Y**	**N**	Sexual Problems	**Y**	**N**	Depression	**Y**	**N**
Testicular Pain	**Y**	**N**	Menstrual Problems	**Y**	**N**			