New Patient History

Name:_____ Date of Visit: _____

Referred by:_____ Date of Birth: _____

Preferred Pharmacy/Location/Phone #: _____

_____

Mail order pharmacy: _____

Reason for your visit:

1. _____
2. _____
3. _____

Current Medications: (Including over the counter and herbal supplements)

Name	Dosage	Times per day

Medication Allergies:

Medication	Reaction

Medical History:

Hypertension_____ Diabetes_____ High Cholesterol_____ Asthma/COPD_____ Sleep Apnea _____

Allergies_____ Acid Reflux_____ Osteoporosis_____ Anxiety/Depression_____ Thyroid Disease_____

Heart Disease_____ Heart Attack/*age*_____ Stroke_____ Cancer: Type_____Age:_____

Other medical issues:_____

Previous Surgeries: Year:

_____

_____

_____

_____

_____

Specialists:

Name: Specialty**:**

_____

_____

_____

_____

_____

Family History:

Mother: Heart disease_____ High blood pressure___ High cholesterol___ Diabetes___ Thyroid disease___

Living/Deceased @age___ Depression/Anxiety___ Osteoporosis __ Stroke___ age__ Cancer Type_____ age____
Other:_____

Father: Heart disease___ High blood pressure___ High cholesterol___ Diabetes_____ Thyroid disease___

Living/Deceased @age___ Depression/Anxiety_____ Osteoporosis____ Stroke___age___ Cancer Type_____age_____
Other:_____

Sibling: Heart disease___ High blood pressure___ High cholesterol___ Diabetes_____ Thyroid disease___

Brother/Sister Living/Deceased Depression/Anxiety_____ Osteoporosis____ Stroke___age___ Cancer Type _____age_____
Other:_____

@age____

Sibling: Heart disease___ High blood pressure___ High cholesterol___ Diabetes_ Thyroid disease___

Brother/Sister Depression/Anxiety_ Osteoporosis___ Stroke__age___ Cancer Type: _____age_____
Living/Deceased Other:_____
@age____

High blood pressure___ High cholesterol___ Diabetes_ Thyroid disease___

Sibling: Heart disease___

Brother/Sister Depression/Anxiety_ Osteoporosis___ Stroke_____age___ Cancer Type:_____ Age:____
Living/Deceased Other:_____
@age____

Other Significant Family History: _____

_____

Social History:

1. Spousal Status: Married Partner Single Divorced Widowed
2. Living Arrangement: Lives alone Lives with:_____
   Assisted Living Retirement community Name of facility:_____
3. # of Children: _____ # of Living children: _____
4. Exercise: # of days per week Duration Type of Exercise

   _____
5. Hobbies: _____
6. Do you currently smoke? Yes/No Packs/Day: _____ # of Years:_____
   Please circle: cigarettes /cigars /pipes

   Have you ever smoked? Yes/No
   What year did you quit smoking? _____

   Do you use smokeless tobacco? Yes/No
   Please circle: chewing tobacco /e-cigs (vaping)

7 .Do you drink alcohol? Yes/No # drinks:_____ day week month year

8.Have you ever used recreational drugs? Yes/No If yes, please list: _____

9. Have you recently traveled outside of the country? Yes/No If yes, where:_____

Review of Systems:

Please circle if you have had recently had problems with any of the following:

General:

Weight gain (How much?)_____ Over how long?_____

Weight loss (How much?) _____ Over how long?_____

Skin

Rash Hair loss Easy bruising Toenail infection

Eyes

Redness Pain Discharge Dryness Visual changes

Nose

Nose bleed Nasal discharge/drainage Sinus pain Sinus congestion

Mouth

Oral lesions White patches Bleeding gums Toothache

Throat

Hoarseness Sore Throat Difficulty swallowing

Respiratory

Cough Coughing up blood Shortness of breath on exertion
Wheezing Shortness of breath on rest

Cardiovascular

Chest discomfort Palpitations (Heart fluttering or racing) Fast heart rate
Difficulty breathing when lying down Awakening short of breath Ankle swelling

Urinary

Pain with urination Urinating frequently Blood in urine
Incontinence (losing your urine) with coughing/laughing Erectile Dysfunction
Urinating before getting to the bathroom
Difficulty starting a urine stream

Gastrointestinal

Nausea/Vomiting Heartburn/Reflux Diarrhea Constipation
Blood in stool Black, tarry stool

Musculoskeletal

Joint pain or stiffness Location:_____
Joint swelling or redness Location:_____
Back pain Muscle pain

Neurological

Difficulty with memory Fainting/Losing consciousness Seizures
Severe or frequent headaches Difficulty walking Lightheadedness
Weakness: Location: _____ Difficulty with balance Vertigo (world spinning around you)

Psychological

Depression Lack of interest in and enjoyment of activities that used to bring pleasure/fulfillment

Decreased sense of self-worth Difficulty focusing and concentrating
Desire to end your life Disabling anxiety Panic attacks

Sleep

Difficulty getting to sleep Difficulty staying asleep Snoring
Cessation of breathing during sleep (as reported by partner)

Health Maintenance / Preventive Screenings:

Immunizations History:

Tetanus (Td/ Tdap)? Yes No No Not sure Date:_____

Shingles vaccine? Yes No No Not sure
Zostavax Date:_____
Shingrix Date #1:_____
Date #2:_____

Pneumonia vaccine? Yes No No Not sure
Pneumovax Date:_____
Prevnar Date:_____

Flu Vaccine this season? Yes No

Colonoscopy? Yes No Not sure Date/Result:_____

Bone density? Yes No Not sure Date/Result:_____

Have you ever had a skin cancer screening check by a dermatologist? Yes No When:____

For Women:

Last mammogram: Date/Result: _____
Last pap smear: Date/Result: _____

Have you ever had an abnormal pap smear? Yes No If yes, date:_____

Have you had a hysterectomy? Yes No If yes, date/reason:_____

For Men:

When did you have your last digital rectal exam or PSA checked? Date:_____