New Patient History

Name: _____ Date of birth: _____

Age: _____ Height: _____ Weight: _____ Handedness: ☐ Left ☐ Right ☐ Ambidextrous

Occupation: _____ Marital status: ☐ Married ☐ Divorced ☐ Widowed ☐ Single

What is the main reason for your visit? Describe your symptoms and how long you have experienced them.

_____

_____

_____

Have you had any tests or specialty evaluations for the problem? Include date, body part, and location.

☐ MRI scans: _____ ☐ Blood tests: _____

☐ CT scans: _____ ☐ Specialty: _____

☐ Vascular studies: _____ ☐ Other: _____

Describe when and how long you have experienced any of the following conditions.

☐ High blood pressure: _____ ☐ Anemia: _____

☐ Diabetes: _____ ☐ Bleeding: _____

☐ Thyroid disease: _____ ☐ Ulcers: _____

☐ Heart failure/CHF: _____ ☐ Arthritis: _____

☐ Heart attack/MI: _____ ☐ HIV/AIDS: _____

☐ Emphysema/COPD: _____ ☐ Lupus: _____

☐ Pneumonia/TB: _____

List any other major illnesses. Include the year of onset.

_____

_____

_____

List any important previous injuries. Include the date of the incident.

_____

_____

_____

List any important hospital visits or surgeries. Include the date, hospital, and reason for admission.

_____

_____

_____

If you have any allergies, check the appropriate box and write your allergy/allergies in the space below.

☐ Drugs/meds ☐ X-ray dye ☐ Other _____

Please complete both sides of this form.

List your medications, including supplements, drops, sprays, birth control, over-the-counter meds, pain pills, etc. If you can't fit them all in the space below, write the list on a separate sheet of paper.

Name of medication *Dosage* *# per day* *Year started* *Year stopped*

_____

_____

_____

_____

_____

_____

Tell us about any tobacco use.

☐ Current smoker: How many cigarettes or packs do you smoke per day? _____

☐ Former smoker: For how many years? _____ Why did you quit? _____

☐ Never a smoker ☐ Light smoker ☐ Other tobacco products: _____

How many alcoholic drinks do you have during an average day?

Weekdays: Bottles/cans of beer: _____ Glasses of wine: _____ Shots of liquor: _____

Weekends: Bottles/cans of beer: _____ Glasses of wine: _____ Shots of liquor: _____

Do you consume significantly less alcohol now than you did in the past? ☐ Yes ☐ No

How many caffeinated drinks do you have during an average day?

Cups of coffee: _____ Cups of tea: _____ Bottles/cans of soda: _____

Write the age of each of your relatives. If they are deceased, write the letter D next to their age at death.

Mother: _____ Sisters: _____ Daughters: _____

Father: _____ Brothers: _____ Sons: _____

Check any conditions that your blood relatives have had.

Mother:	**Father:**	**Sisters:**	**Brothers:**	**Daughters:**	**Sons:**
☐ Headaches	☐ Headaches	☐ Headaches	☐ Headaches	☐ Headaches	☐ Headaches
☐ Stroke	☐ Stroke	☐ Stroke	☐ Stroke	☐ Stroke	☐ Stroke
☐ Epilepsy/seizures	☐ Epilepsy/seizures	☐ Epilepsy/seizures	☐ Epilepsy/seizures	☐ Epilepsy/seizures	☐ Epilepsy/seizures
☐ Multiple sclerosis	☐ Multiple sclerosis	☐ Multiple sclerosis	☐ Multiple sclerosis	☐ Multiple sclerosis	☐ Multiple sclerosis
☐ Parkinson's disease	☐ Parkinson's disease	☐ Parkinson's disease	☐ Parkinson's disease	☐ Parkinson's disease	☐ Parkinson's disease
☐ Alzheimer's disease	☐ Alzheimer's disease	☐ Alzheimer's disease	☐ Alzheimer's disease	☐ Alzheimer's disease	☐ Alzheimer's disease
☐ Brain tumor	☐ Brain tumor	☐ Brain tumor	☐ Brain tumor	☐ Brain tumor	☐ Brain tumor
☐ Other neurological	☐ Other neurological	☐ Other neurological	☐ Other neurological	☐ Other neurological	☐ Other neurological
☐ Diabetes	☐ Diabetes	☐ Diabetes	☐ Diabetes	☐ Diabetes	☐ Diabetes
☐ Hypertension	☐ Hypertension	☐ Hypertension	☐ Hypertension	☐ Hypertension	☐ Hypertension
☐ Cancer	☐ Cancer	☐ Cancer	☐ Cancer	☐ Cancer	☐ Cancer
☐ Heart disease	☐ Heart disease	☐ Heart disease	☐ Heart disease	☐ Heart disease	☐ Heart disease
☐ Thyroid	☐ Thyroid	☐ Thyroid	☐ Thyroid	☐ Thyroid	☐ Thyroid
☐ Lung disease	☐ Lung disease	☐ Lung disease	☐ Lung disease	☐ Lung disease	☐ Lung disease
☐ Kidney disease	☐ Kidney disease	☐ Kidney disease	☐ Kidney disease	☐ Kidney disease	☐ Kidney disease
☐ Psychiatric problems	☐ Psychiatric problems	☐ Psychiatric problems	☐ Psychiatric problems	☐ Psychiatric problems	☐ Psychiatric problems

Tell us anything else we should know about your family history. Are other diseases common in your family?

_____

_____