New Patient History

Name: _____ Date of birth: _____ Occupation: _____

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

Marital status: ☐ Married ☐ Single ☐ Widowed ☐ Divorced

List the physicians you see regularly. We will send them copies of our office notes unless we are instructed not to.

Primary care physician: _____ Other physicians: _____

What is the main reason for your visit? How long have you been experiencing the problem? Describe your symptoms.

_____

_____

_____

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

☐ MRI scans: _____ ☐ CAT scans: _____

☐ Vascular studies: _____ ☐ Blood tests: _____

☐ Specialties: _____ ☐ 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.

Year of onset: _____ Type of illness: _____

Year of onset: _____ Type of illness: _____

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Year of onset: _____ Type of illness: _____

List any important previous injuries.

Date of incident: _____ Injury: _____

Date of incident: _____ Injury: _____

Date of incident: _____ Injury: _____

List any important hospital visits and/or surgeries.

Visit date: _____ Hospital: _____ Reason for visit: _____

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Do you have any allergies? If you do, mark the applicable boxes and write your allergy/allergies in the space below.

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

Please complete the reverse side of this form.

List your medications, including supplements, drops, sprays, birth control, over-the-counter meds, pain pills, etc.

Name of medication	Dose (mg)	# per day	When started	When 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

☐ Other tobacco products: _____

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

Weekdays: Bottles or cans of beer: _____ Glasses of wine: _____ Shots or ounces of liquor: _____

Weekends: Bottles or cans of beer: _____ Glasses of wine: _____ Shots or ounces 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 or cans of caffeinated cola drinks: _____

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

Mother: _____ Sisters: _____ _____ _____ _____ Daughters: _____ _____ _____ _____

Father: _____ Brothers: _____ _____ _____ _____ Sons: _____ _____ _____ _____

Indicate 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 that we should know about your family history. Are any other diseases common in your family?

_____

_____

_____