

Welcome to our practice. As a new patient, please fill out the information found below to the best of your ability.

Date: _____

Patient Name _____ Birthdate _____ Patient # _____

Chief Complaint: _____

History of present illness:

Location: _____
(Where is the pain/problem?)

Quality _____
(Example: normal versus abnormal color, activity, etc.)

Severity _____
(How severe is the pain/problem on a scale of 1-5 with 5 being the most severe?)

Duration _____
(How long have you had this pain/problem?, or, When did it start?)

Timing _____
(Does the pain/problem occur at a specific time?)

Context _____
(Where were you at the onset of this pain/problem?)

Associated signs/symptoms _____
(What other associated problems have you been having?)

Modifying factors _____
(What makes the pain/problem worse or better?, or, Have you had previous episodes?)

Past Medical History

Have you ever had the following: (Circle "no" or "yes", leave blank if uncertain)

Measles	no	yes	Anemia	no	yes	Back trouble	no	yes	Hepatitis	no	yes
Mumps	no	yes	Bladder Infections	no	yes	High Blood Pressure	no	yes	Ulcer	no	yes
Chickenpox	no	yes	Epilepsy	no	yes	Low Blood Pressure	no	yes	Kidney Disease	no	yes
Whooping Cough	no	yes	Migraine Headaches	no	yes	Hemorrhoids	no	yes	Thyroid Disease	no	yes
Scarlet Fever	no	yes	Tuberculosis	no	yes	Date of last chest x-ray	_____	Bleeding Tendency	no	yes	
Diphtheria	no	yes	Diabetes	no	yes	Asthma	no	yes	Any other disease	no	yes
Smallpox	no	yes	Cancer	no	yes	Hives or Eczema	no	yes	(please list):	_____	_____
Pneumonia	no	yes	Polio	no	yes	AIDS or HIV+	no	yes	_____	_____	_____
Rheumatic Fever	no	yes	Glaucoma	no	yes	Infectious Mono	no	yes	_____	_____	_____
Heart Disease	no	yes	Hernia	no	yes	Bronchitis	no	yes	_____	_____	_____
Arthritis	no	yes	Blood or Plasma Transfusions	no	yes	Mitral Valve Prolapse	no	yes	_____	_____	_____
Venereal Disease	no	yes				Stroke	no	yes	_____	_____	_____

Previous Hospitalizations/Surgeries/Serious Illnesses	When?	Hospital, City, State
_____	_____	_____
_____	_____	_____
_____	_____	_____

Medications: (Include nonprescription) _____

Have you ever taken Phen-Fen/Redux? no yes

Patient social history:

Marital status: Single: _____ Married: _____ Separated: _____ Divorced: _____ Widowed: _____
 Use of alcohol: Never: _____ Rarely: _____ Moderate: _____ Daily: _____
 Use of tobacco: Never: _____ Previously, but quit: _____ Current packs / day: _____
 Use of drugs: Never: _____ Type/Frequency: _____
 Excessive exposure at home or work to: Fumes: _____ Dust: _____ Solvents: _____ Air-borne Particles: _____ Noise: _____

Family medical history:

	Age	Diseases	If Deceased, Cause of Death
Father	_____	_____	_____
Mother	_____	_____	_____
Siblings	_____	_____	_____
_____	_____	_____	_____
Spouse	_____	_____	_____
Children	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Review of Systems: Please indicate any personal history below:

<input type="checkbox"/> Constitutional Symptoms Good general health lately No Yes Recent weight change No Yes Fever No Yes Fatigue No Yes Headaches No Yes		<input type="checkbox"/> Genitourinary Frequent urination No Yes Burning or painful urination No Yes Blood in urine No Yes Change in force of strain when urinating No Yes Incontinence or dribbling No Yes Kidney stones No Yes Sexual difficulty No Yes Male - testicle pain No Yes Female - pain with periods No Yes Female - irregular periods No Yes Female - vaginal discharge No Yes Female - # of pregnancies _____ Female - # of miscarriages _____ Female - date of last pap smear _____		<input type="checkbox"/> Psychiatric Memory loss or confusion No Yes Nervousness No Yes Depression No Yes Insomnia No Yes Suicidal Thoughts No Yes Violent or Unusual Thoughts No Yes	
<input type="checkbox"/> Eyes Eye disease or injury No Yes Wear glasses/contact lenses No Yes Blurred or double vision No Yes		<input type="checkbox"/> Musculoskeletal Joint pain No Yes Joint stiffness or swelling No Yes Weakness of muscles or joints No Yes Muscle pain or cramps No Yes Back pain No Yes Cold extremities No Yes Difficulty in walking No Yes		<input type="checkbox"/> Endocrine Glandular or hormone problem No Yes Excessive thirst or urination No Yes Heat or cold intolerance No Yes Skin becoming drier No Yes Change in hat or glove size No Yes	
<input type="checkbox"/> Ears/Nose/Mouth/Throat Hearing loss or ringing No Yes Earaches or drainage No Yes Chronic sinus problem or rhinitis No Yes Nose bleeds No Yes Mouth sores No Yes Bleeding gums No Yes Bad breath or bad taste No Yes Sore throat or voice change No Yes Swollen glands in neck No Yes		<input type="checkbox"/> Integumentary (skin, breast) Rash or itching No Yes Change in skin color No Yes Change in hair or nails No Yes Varicose veins No Yes Breast pain No Yes Breast lump No Yes Breast discharge No Yes		<input type="checkbox"/> Hematologic/Lymphatic Slow to heal after cuts No Yes Bleeding or bruising tendency No Yes Anemia No Yes Phlebitis No Yes Past transfusion No Yes Enlarged glands No Yes	
<input type="checkbox"/> Cardiovascular Heart trouble No Yes Chest pain or angina pectoris No Yes Palpitation No Yes Shortness of breath w/walking or lying flat No Yes Swelling of feet, ankles or hands No Yes		<input type="checkbox"/> Neurological Frequent or recurring headaches No Yes Light headed or dizzy No Yes Convulsions or seizures No Yes Numbness or tingling sensations No Yes Tremors No Yes Paralysis No Yes Head injury No Yes		<input type="checkbox"/> Allergic/Immunologic History of skin reaction or other adverse reaction to: Penicillin or other antibiotics No Yes Morphine, Demerol, or other narcotics No Yes Novocain or other anesthetics No Yes Aspirin or other pain remedies No Yes Tetanus antitoxin or other serums No Yes Iodine, Merthiolate or other antiseptic No Yes Other drugs/medications: _____ _____ Known food allergies: _____ _____ Environmental allergies: _____ _____	
<input type="checkbox"/> Respiratory Persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)? No Yes Spitting up blood No Yes Shortness of breath No Yes Wheezing No Yes		<input type="checkbox"/> Gastrointestinal Loss of appetite No Yes Change in bowel movements No Yes Nausea or vomiting No Yes Frequent diarrhea No Yes Painful bowel movements or constipation No Yes Rectal bleeding or blood in stool No Yes Abdominal pain No Yes			

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the healthcare staff to perform the necessary services I may need.

Signature of Parent or Guardian

Date

Doctor's Review

Signature of Doctor

Date