

New Patient Medical History Form



Name: _____ Date of Birth: _____ Today's Date: _____

Reason you are here: _____

Personal Medical History: Have you ever had any of the following conditions? (Check if yes)

<input type="checkbox"/> Anemia	<input type="checkbox"/> Crohn's Disease	<input type="checkbox"/> HIV/ AIDS
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Depression	<input type="checkbox"/> Hypertension
<input type="checkbox"/> Asthma	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Kidney Disease
<input type="checkbox"/> Cancer	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Myocardial Infarction
<input type="checkbox"/> Chronic Obstructive Pulmonary Disease	<input type="checkbox"/> Endocrine Problems	<input type="checkbox"/> Peptic Ulcer Disease
<input type="checkbox"/> Clotting Disorder	<input type="checkbox"/> GERD	<input type="checkbox"/> Seizures
<input type="checkbox"/> Congestive Heart Failure	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Stroke
	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Ulcerative Colitis

Personal Surgical History: Have you ever had any of the following surgeries? (Check if yes)

<input type="checkbox"/> Adrenal Gland Surgery	<input type="checkbox"/> Colon Surgery	<input type="checkbox"/> Kidney Surgery
<input type="checkbox"/> Appendectomy	<input type="checkbox"/> Coronary Artery Bypass Graft	<input type="checkbox"/> Neck Surgery
<input type="checkbox"/> Bariatric Surgery	<input type="checkbox"/> Esophagus Surgery	<input type="checkbox"/> Prostate Surgery
<input type="checkbox"/> Bladder Surgery	<input type="checkbox"/> Gastric Bypass Surgery	<input type="checkbox"/> Small Intestine Surgery
<input type="checkbox"/> Breast Surgery	<input type="checkbox"/> Hemorrhoid Surgery	<input type="checkbox"/> Spine Surgery
<input type="checkbox"/> Cesarean Section	<input type="checkbox"/> Hernia Repair	<input type="checkbox"/> Stomach Surgery
<input type="checkbox"/> Cholecystectomy	<input type="checkbox"/> Hysterectomy	<input type="checkbox"/> Thyroid Surgery

List names and dates of surgeries: _____

Medications: _____

Allergies: _____

Family History: Has anyone in your family had any of the following conditions? (Check if yes, and indicate relationship to you)

<input type="checkbox"/> Cancer/Polyps _____ Colon, Rectum, Anal, Stomach, Breast, Prostate, Uterus, Ovaries, Thyroid, Lung, Blood, Lymphoma Other _____	<input type="checkbox"/> Anemia _____ <input type="checkbox"/> Diabetes _____ <input type="checkbox"/> Blood Clots _____ <input type="checkbox"/> Heart Disease _____ <input type="checkbox"/> Stroke _____	<input type="checkbox"/> High Blood Pressure _____ <input type="checkbox"/> Anesthesia Reaction _____ <input type="checkbox"/> Bleeding Problems _____ <input type="checkbox"/> Hepatitis _____ <input type="checkbox"/> Other _____
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Social History:

Alcohol use - Never Occasionally Daily Type _____
 Tobacco use - Never Previously, but quit Packs Per Day _____ for _____ years
 Drugs use - Never Occasionally Daily Type _____

What is your occupation? _____

Marital Status: Single, Married, Divorced, Widowed, Separated

Name of spouse or significant other _____

Children: Number of Children _____ Number of grandchildren _____

Women: Number of pregnancies _____, Number of deliveries _____ - Vaginal _____, C-sections _____,

Miscarriages _____, VIPs (abortions) _____

Cancer health habits: (Circle response)

Women				Men			
Breast:	Monthly self-exam	Y	N	Prostate:	Yearly rectal exam	Y	N
	Yearly physician exam	Y	N		Yearly PSA blood test	Y	N
	Last mammogram	Y	N				
GYN:	Yearly GYN exam	Y	N				
	Yearly PAP exam	Y	N				
All							
Skin:	High sun exposure	Y	N	Colon:	Yearly rectal exam	Y	N
	Yearly skin exam	Y	N		Yearly stool test for blood	Y	N
					Date of last colonoscopy _____		

Review of Systems: Do you currently have any of the following symptoms or conditions (Check if yes)

<p>General: <input type="checkbox"/> Nothing in this group</p> <p><input type="checkbox"/> Weight loss – How much _____ lbs</p> <p><input type="checkbox"/> Loss of Appetite</p> <p><input type="checkbox"/> Fever</p> <p><input type="checkbox"/> Chills</p> <p><input type="checkbox"/> Night Sweats</p> <p><input type="checkbox"/> Fainting Spells</p> <p>Eyes: <input type="checkbox"/> Nothing in this group</p> <p><input type="checkbox"/> Eye disease or injury</p> <p><input type="checkbox"/> Wear glasses or contacts</p> <p><input type="checkbox"/> Blurred or double vision</p> <p>Ear, Nose, Mouth, Throat: <input type="checkbox"/> Nothing in this group</p> <p><input type="checkbox"/> Hearing loss</p> <p><input type="checkbox"/> Ear ache / infection</p> <p><input type="checkbox"/> Ringing in ears</p> <p><input type="checkbox"/> Nose Bleeds</p> <p><input type="checkbox"/> Bleeding gums</p> <p><input type="checkbox"/> Mouth sores</p> <p><input type="checkbox"/> Sore throat</p> <p><input type="checkbox"/> Recent voice change</p> <p><input type="checkbox"/> Runny nose / cold</p> <p><input type="checkbox"/> Sinus problems</p> <p><input type="checkbox"/> Neck stiffness / pain</p> <p><input type="checkbox"/> Enlarged neck glands / masses</p>	<p>Cardiovascular: <input type="checkbox"/> Nothing in this group</p> <p><input type="checkbox"/> Chest pain</p> <p><input type="checkbox"/> Palpitations</p> <p><input type="checkbox"/> Heart valve problems</p> <p><input type="checkbox"/> Calf pain with walking</p> <p><input type="checkbox"/> Leg swelling</p> <p>Respiratory: <input type="checkbox"/> Nothing in this group</p> <p><input type="checkbox"/> Chronic cough</p> <p><input type="checkbox"/> Coughing up blood</p> <p><input type="checkbox"/> Short of breath with activity</p> <p><input type="checkbox"/> Short of breath lying flat</p> <p><input type="checkbox"/> Wheezing</p> <p><input type="checkbox"/> Asthma</p> <p><input type="checkbox"/> Bronchitis</p> <p><input type="checkbox"/> Pneumonia</p> <p>Musculoskeletal: <input type="checkbox"/> Nothing in this group</p> <p><input type="checkbox"/> Joint pain</p> <p><input type="checkbox"/> Arthritis</p> <p><input type="checkbox"/> Back pain</p> <p><input type="checkbox"/> Muscle weakness</p> <p><input type="checkbox"/> Leg pain with walking</p> <p><input type="checkbox"/> Leg pain at rest</p> <p><input type="checkbox"/> Broken bones _____</p>
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<p>Digestive: <input type="checkbox"/> Nothing in this group</p> <ul style="list-style-type: none"> <input type="checkbox"/> Loss of appetite <input type="checkbox"/> Difficulty swallowing <input type="checkbox"/> Early satiety (fill up easy) <input type="checkbox"/> Heartburn <input type="checkbox"/> Nausea <input type="checkbox"/> Vomiting <input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation <input type="checkbox"/> Blood in stool <input type="checkbox"/> Dark, tarry stools <input type="checkbox"/> Abdominal pain <input type="checkbox"/> Painful bowel movements <input type="checkbox"/> Poor control of BMs, urgency <p>Urinary: <input type="checkbox"/> Nothing in this group</p> <ul style="list-style-type: none"> <input type="checkbox"/> Burning with urination <input type="checkbox"/> Weak urine stream <input type="checkbox"/> Blood in urine <input type="checkbox"/> Gas or stool in urine <input type="checkbox"/> Poor control, leakage of urine <input type="checkbox"/> Kidney stones <input type="checkbox"/> Prostate problems <input type="checkbox"/> Testicular mass <input type="checkbox"/> Get up at night to urinate - Number of times per night _____ 	<p>Neurological: <input type="checkbox"/> Nothing in this group</p> <ul style="list-style-type: none"> <input type="checkbox"/> Frequent headaches <input type="checkbox"/> Migraines <input type="checkbox"/> Weakness <input type="checkbox"/> Seizures <input type="checkbox"/> Stroke <input type="checkbox"/> Paralysis <input type="checkbox"/> Decreased sensation <input type="checkbox"/> Difficulty with speech <input type="checkbox"/> Dizziness <p>Psychiatric: <input type="checkbox"/> Nothing in this group</p> <ul style="list-style-type: none"> <input type="checkbox"/> Anxiety <input type="checkbox"/> Depression <input type="checkbox"/> Mood swings <input type="checkbox"/> Phobias, fears _____ <input type="checkbox"/> Panic attacks <input type="checkbox"/> Suicide thoughts or attempts <p>Endocrine: <input type="checkbox"/> Nothing in this group</p> <ul style="list-style-type: none"> <input type="checkbox"/> Heat or cold intolerance <input type="checkbox"/> Excessive thirst <input type="checkbox"/> Excessive urination <input type="checkbox"/> Excessive Sweating
<p>Gynecologic (female): <input type="checkbox"/> Nothing in this group</p> <ul style="list-style-type: none"> <input type="checkbox"/> Irregular periods - Last period: _____ <input type="checkbox"/> Abnormal vaginal discharge <p>Breast: <input type="checkbox"/> Nothing in this group</p> <ul style="list-style-type: none"> <input type="checkbox"/> Breast lump <input type="checkbox"/> Breast pain <input type="checkbox"/> Nipple discharge <p>Skin: <input type="checkbox"/> Nothing in this group</p> <ul style="list-style-type: none"> <input type="checkbox"/> Rash <input type="checkbox"/> Skin infections <input type="checkbox"/> Ulcers or sores <input type="checkbox"/> Yellowing of the skin <input type="checkbox"/> Eczema, psoriasis, other _____ <input type="checkbox"/> Pyoderma gangrenosum, erythema nodosum 	<p>Hematologic, Lymphatic: <input type="checkbox"/> Nothing in this group</p> <ul style="list-style-type: none"> <input type="checkbox"/> Prior blood transfusion <input type="checkbox"/> Easy bleeding or bruising <input type="checkbox"/> Low red blood cell count (anemia) <input type="checkbox"/> Low white blood cell count <input type="checkbox"/> Prolonged bleeding with cuts, surgery <input type="checkbox"/> Swollen glands <input type="checkbox"/> Blood clots <input type="checkbox"/> Use of blood thinners <input type="checkbox"/> Swollen lymph nodes <p>Allergic, Immunologic: <input type="checkbox"/> Nothing in this group</p> <ul style="list-style-type: none"> <input type="checkbox"/> HIV infection <input type="checkbox"/> Hepatitis <input type="checkbox"/> Immune deficiency <input type="checkbox"/> Antibiotics needed for dental work

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