# Welcome to Our Practice

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

Patient # _____ Physician _____ Date _____

Patient name _____ 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 (5 being the most severe))

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

**Timing** _____ (Does this 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? Have you had previous episodes?)

## Patient Medical History:

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

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

**Previous Hospitalizations/Surgeries/Serious Illnesses**

| | When | Hospital, city, state |
|---|---|---|
| | | |
| | | |
| | | |

**Medications** (include nonprescription):

## 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 | ☐ Airborne particles | ☐ Noise |

## Family Medical History:

| | Age | Diseases | If deceased, cause of death |
|---|---|---|---|
| Father | | | |
| Mother | | | |
| Siblings | | | |
| | | | |
| Spouse | | | |
| Children | | | |
| | | | |

Over Please

# Review of Systems: Please indicate any personal history below.

### CONSTITUTIONAL SYMPTOMS

| | | |
|---|---|---|
| Good general health lately | ☐ No | ☐ Yes |
| Recent weight change | ☐ No | ☐ Yes |
| Fever | ☐ No | ☐ Yes |
| Fatigue | ☐ No | ☐ Yes |
| Headaches | ☐ No | ☐ Yes |

### EYES

| | | |
|---|---|---|
| Eye disease or injury | ☐ No | ☐ Yes |
| Wear glasses/contact lenses | ☐ No | ☐ Yes |
| Blurred or double vision | ☐ No | ☐ Yes |

### EARS/NOSE/MOUTH/THROAT

| | | |
|---|---|---|
| Hearing loss or ringing | ☐ No | ☐ Yes |
| Earaches or drainage | ☐ No | ☐ Yes |
| Chronic sinus problems 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 |

### CARDIOVASCULAR

| | | |
|---|---|---|
| Heart trouble | ☐ No | ☐ Yes |
| Chest pain or angina pectoris | ☐ No | ☐ Yes |
| Palpitation | ☐ No | ☐ Yes |
| Shortness of breath walking or lying flat | ☐ No | ☐ Yes |
| Swelling of feet, ankles or hands | ☐ No | ☐ Yes |

### RESPIRATORY

| | | |
|---|---|---|
| Chronic or frequent coughs | ☐ No | ☐ Yes |
| Spitting up blood | ☐ No | ☐ Yes |
| Shortness of breath | ☐ No | ☐ Yes |
| Wheezing | ☐ No | ☐ Yes |

### 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 |

### 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: _____

### 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 |

### 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 |

### 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 |

### PSYCHIATRIC

| | | |
|---|---|---|
| Memory loss or confusion | ☐ No | ☐ Yes |
| Nervousness | ☐ No | ☐ Yes |
| Depression | ☐ No | ☐ Yes |
| Insomnia | ☐ No | ☐ Yes |

### ENDOCRINE

| | | |
|---|---|---|
| Glandular or hormone problem | ☐ No | ☐ Yes |
| Excessive thirst or urination | ☐ No | ☐ Yes |
| Heat or cold intolerance | ☐ No | ☐ Yes |
| Skin becoming dryer | ☐ No | ☐ Yes |
| Change in hat or glove size | ☐ No | ☐ Yes |

### 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 |

### 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, methiolate or other antiseptics | ☐ No | ☐ Yes |

Other drugs/medications: _____

Known food allergies: _____

Environmental allergies: _____

### AUTHORIZATION & RELEASE

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.

X _____ _____

Signature of patient (or parent if minor) Date

Doctor's Review: _____

_____

_____

_____

_____

_____

_____

_____

Signature of Doctor Date