

NEW PATIENT INFORMATION FORM

Name: _____ Ht _____ Wt _____

Date: _____ Are you here for your Well Woman Exam? _____

If not, what is your Chief Complaint? _____

Medical History-

Diabetes	No / Yes	All Hospitalizations/Surgeries/Major injuries
Hypertension	No / Yes	_____
Cancer	No / Yes	_____
Stroke	No / Yes	_____
Heart trouble	No / Yes	_____
Arthritis/gout	No / Yes	_____
Convulsions	No / Yes	Medications including prescription, over-the-counter, Vitamins, herbs and supplements
Bleeding tendency	No / Yes	_____
Acute infections	No / Yes	_____
Venereal disease	No / Yes	_____
Hereditary defects	No / Yes	_____

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 _____

Page two

Name _____

Family Medical History

	<u>Age</u>	Major medical problems, for example Cancer, diabetes, osteoporosis, etc.	<u>If deceased, cause of death</u>
Father	_____	_____	_____
Mother	_____	_____	_____
Siblings	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
Spouse	_____	_____	_____
Children	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____

Please answer the following questions that are related to you personally

CONSTITUTIONAL SYMPTOMS

Good general health lately N / Y
Recent weight change N / Y
Fever N / Y
Fatigue N / Y
Headaches N / Y

MUSCULSKELETAL

Joint pain N / Y
Joint stiffness/swelling N / Y
Weakness of muscles/joints N / Y
Back pain N / Y
Cold extremities N / Y
Difficulty in walking N / Y

Page three

Name _____

EYES

Eye disease or injury N / Y
Wear glasses/contacts N / Y
Blurred or double vision N / Y
Glaucoma N / Y

INTEGUMENTARY (SKIN, BREAST)

Rash or itching N / Y
Change in skin color N / Y
Change in hair or nails N / Y
Varicose veins N / Y
Breast pain N / Y
Breast lump N / Y
Breast discharge N / Y

EAR/NOSE/MOUTH/THROAT

Hearing loss or ringing N / Y
Earaches or drainage N / Y
Chronic sinus problems N / Y
Nose bleeds N / Y
Bad breath or taste N / Y
Sore throat / voice change N / Y
Swollen glands in neck N / Y

NEUROLOGICAL

Frequent/ recurrent headaches N / Y
Lightheaded or dizzy N / Y
Convulsions or seizures N / Y
Numbness or tingling N / Y
Tremors N / Y
Paralysis N / Y
Stroke N / Y
Head injury N / Y

CARDIOVASCULAR

Heart trouble N / Y
Chest pain/ angina N / Y
Palpitations N / Y
Shortness of breath N / Y
Swelling: feet, ankles N / Y

PSYCHIATRIC

Memory loss or confusion N / Y
Nervousness N / Y
Depression N / Y
Anxiety N / Y
Insomnia N / Y

RESPIRATORY

Chronic or frequent cough N / Y
Spitting up blood N / Y
Shortness of breath N / Y
Asthma or wheezing N / Y

ENDOCRINE

Glandular or hormone problems N / Y
Thyroid disease N / Y
Diabetes N / Y
Excessive thirst or urination N / Y
Heat or cold intolerance N / Y
Skin becoming dry N / Y
Change in hat or glove size N / Y

Page four

Name _____

GASTROINTESTINAL

Loss of appetite N / Y
Change in bowel habits N / Y
Nausea or vomiting N / Y
Painful bowel movements N / Y
Constipation N / Y
Rectal bleeding N / Y
Blood in stool N / Y
Abdominal pain N / Y
Heartburn N / Y
Peptic ulcer N / Y

HEMATOLOGICAL/LYMPHATIC

Slow to heal after cuts N / Y
Bleeding or bruising tendency N / Y
Anemia N / Y
Phlebitis N / Y
Past transfusion N / Y
Enlarged glands N / Y

ALLERGIC/IMMUNOLOGICAL

History of skin reaction or other adverse reaction to:

Penicillin or other antibiotics N / Y
Morphine, Demerol, or other narcotics N / Y
Novocain or other anesthetics N / Y
Aspirin or other pain relievers N / Y
Tetanus or other serums N / Y
Iodine, merthiolate or other antiseptic N / Y
Other drugs or medications _____

Food allergies _____

GENITOURINARY

Frequent urination N / Y
Burning or painful urination N / Y
Blood in urine N / Y
Change in force of stream N / Y
Incontinence or dribbling N / Y
Kidney stones N / Y
Sexual difficulty N / Y
Pain with periods N / Y
Irregular periods N / Y
Unusual vaginal discharge N / Y

of pregnancies _____ # of miscarriages _____

Date of last Pap smear _____

Page five

Name _____

Safety/Health

Do you wear seat belts	N / Y
Do you wear a bike helmet	N / Y
If there is a gun in your home, is it Out of children's reach, unloaded	N / Y
Do you use drugs (marijuana, Cocaine, crack, etc.	N / Y
Have you ever engaged in any Activity which has put you at risk of getting AIDS	N / Y
Do you wish to be tested for AIDS	N / Y
Are you in a relationship in which You have been physically hurt (e.g. Slapped, kicked, punched, bruised) By your partner	N / Y
Do you ever feel afraid of your Partner	N / Y
Do you have a donor card	N / Y
Do you eat a well-balanced diet	N / Y
Do you exercise regularly	N / Y
Do you know how to reduce stress	N / Y

Physician's signature and date: _____