New Patient History Database

Name: _______________________________ Date: ___________

Date of birth: ____________________ Age: ______

Are you right-handed or left-handed? __________

Sex: male female Identify as: male female

Primary physician, NP or PA: ______________________

Pharmacy name: ___________________________________City ________________ State ____

Reason for visit: ____

Allergies (drugs, foods, shellfish, iodine, latex):

____

Past Medical History: Select all you have now or had in the past

Asthma	Blindness	Cancer (type/date) _____________________
Deafness	Dementia	Diabetes
Fibromyalgia	Head injury	Heart attack
High blood pressure	High Cholesterol	Kidney stones
Multiple sclerosis	Parkinson Disease	Psychiatric illness (type) _________________
Seizures	Sleep apnea	Thyroid disease

Other ____

List all prior surgeries:

___________________ ____________________ ____________________ ____________________

___________________ ____________________ ____________________ ____________________

Social History:

Occupation: _______________ Marital status: Married Single Widowed Divorced

Number of children: _____________

If you use alcohol, how much do you drink in a week? ____________drinks

If you smoke, how many packs per day? _____packs How many years? _____years

If you smoked in the past, when did you stop? ______

Family History: Select all that apply and state which relative on mother's side or father's side

Cancer (type) ____________________

Dementia _______________________

Diabetes ________________________

Headaches ______________________

Heart trouble ____________________

High blood pressure _______________

Muscle disease ________________________

Neuropathy ___________________________

Parkinson disease ______________________

Psychiatric disease _____________________

Seizures ______________________________

Thyroid disease ________________________

List all your current medications and doses, including over the counter medications:

_____________________________________ ___________________________________

_____________________________________ ___________________________________

_____________________________________ ____________________________________

_____________________________________ ____________________________________

_____________________________________ ____________________________________

_____________________________________ ____________________________________

Review of Systems: Select all that apply. Items not selected are considered negative/normal.

Constitutional:

Appetite change Fatigue Weight gain/loss of _____pounds

Eyes:

Vision problems Wear glasses/contacts Glaucoma

Ears, nose, throat:

Difficulty swallowing Dizziness Hearing loss

Respiratory:

Cough   Shortness of breath   Wheezing

Heart:

Chest pain   Loss of consciousness   Palpitations

Abdomen:

Pain   Constipation   Diarrhea   Nausea/vomiting   Blood in stools

Genitourinary:

Burning with urination   Urinary urgency   Loss of bladder control

Prostrate problems

Last menstruation: _____________   Currently pregnant: Yes   No

Planning pregnancy in next year: Yes   No

Skin:

Recent rash   New moles

Breasts:

Month or year of last mammogram __________

Musculoskeletal:

Arthritis   Osteopenia/osteoporosis   Edema

Back pain   Neck pain

Hematologic/oncologic:

Chemotherapy   Clotting issues

Neurologic:

Numbness: right arm,   left arm,   right leg,   left leg

Weakness: right arm,   left arm,   right leg,   left leg