



MRN (office use only): _____

New Patient History Form (Adult)

New Patients, please take a moment to fill out both pages and complete all areas to the best of your knowledge. In doing so we will have a better understanding of you and target any concerns/issues you may have. **Existing Patients** please fill out both pages and complete all areas to the best of your knowledge. This will allow us to review your medical history and updates changes that may have occurred over the past year.

Name: _____ Date of Birth: _____ Date: _____

Marital Status: _____ Name of Spouse or Significant Other: _____

Children (include age): _____

Education: _____ Profession: _____

Do you currently have a living will? **Y N** Do you have a power of attorney? **Y N**

MEDICATIONS: Please list all medications you are currently taking and include dose and frequency, including over the counter and herbal supplements.

| | |
|----|-----|
| 1. | 6. |
| 2. | 7. |
| 3. | 7. |
| 4. | 9. |
| 5. | 10. |

PAST MEDICAL HISTORY: Please list all medical conditions for which you have been treated in the past

| | |
|----|-----|
| 1. | 6. |
| 2. | 7. |
| 3. | 8. |
| 4. | 9. |
| 5. | 10. |

ALLERGIES: Please list all medications you are allergic to and the allergic reaction that occurs.

Please check box if you are allergic to latex: Please check box if you have no known allergies:

| | |
|----|----|
| 1. | 3. |
| 2. | 4. |

IMMUNIZATIONS: Please date your most recent immunization

Hepatitis A _____ Flu Shot _____ Tetanus _____ Shingles _____
 Hepatitis B _____ Chicken Pox _____ Meningitis _____
 HPV _____ Pneumonia _____ MMR _____ Other _____

PAST SURGICAL HISTORY: Please list all operations and dates

| | |
|----|----|
| 1. | 4. |
| 2. | 5. |
| 3. | 6. |

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Name: _____ Date of Birth: _____

FAMILY HISTORY: Please list every family members age (or age at death) and any illnesses: cancer, diabetes, heart disease, high blood pressure, lung problems, kidney problems, depression, arthritis, and allergies

| | |
|------------------------------|------------------------------|
| Mother: | Father: |
| Maternal Grandfather: | Maternal Grandmother: |
| Paternal Grandfather: | Paternal Grandmother: |
| Siblings: | Children: |

WOMEN:

Number of pregnancies _____ Children _____ Miscarriages _____ Abortions _____

Last pap smear _____ Have you had an abnormal pap? **Y N** Last period _____ Age at Menopause _____

Age at first period _____ Last bone density scan _____ Last Mammogram _____

MEN:

Last prostate exam _____ Last prostate blood test (PSA) _____

BOTH:

Last colonoscopy / sigmoidoscopy _____

SYSTEM REVIEW: Please mark the box if you have experienced any of the following symptoms within the last 6 months.

GENERAL:

Fever _____
Chills _____
Headaches _____
Night Sweats _____
Appetite Change _____
Unexplained Weight Loss/gain _____
Fatigue _____

EYES:

Eye pain with sunlight _____
Vision change _____
Redness _____
Discharge _____
Pain _____
Itching _____
Glasses _____
Glaucoma _____

EARS/NOSE/THROAT:

Hearing loss _____ Ringing in ear _____
Nosebleeds _____ Runny nose _____
Nasal congestion _____ Earache _____
Post nasal drip _____ Sore throat _____
Mouth sores _____ Dentures _____

HEART:

Palpitations _____ Leg swelling _____
Passing out _____ Leg pain while walking _____
Chest pain _____
Difficulty breathing at night _____

LUNGS:

Cough _____
Coughing blood _____
Shortness of breath _____
Wheezing _____
Coughing up phlegm _____

STOMACH/INTESTINES:

Belly pain _____ Nausea _____
Vomiting _____ Diarrhea _____
Constipation _____ Bloody stool _____
Dark stool _____ Heartburn _____
Trouble breathing _____

URINARY TRACT:

Pain w/ urination _____
Blood in urine _____
Sudden urges to urinate _____
Urinating more frequently _____
Incontinence _____
Decrease stream _____

WOMEN:

Vaginal itching _____
Vaginal discharge _____
Abdominal vaginal bleeding _____

MEN:

Testicular pain _____
Testicular mass/swelling _____
Penile discharge _____
Erectile dysfunction _____

BREAST:

Pain _____ Lumps _____ Discharge _____ Implants _____

MUSCULOSKELTAL:

Joint pain _____ Stiffness _____ Weakness _____
Joint swelling _____ Back pain _____
Muscle pain _____ Muscle cramps _____

SKIN

Itching _____ Redness _____ Rash _____ Hair loss _____
Nail change _____ Moles _____ Dry skin _____

NEUROLOGIC:

Memory loss _____ Numbness _____
Problems walking _____ Problems speaking _____
Dizziness _____ Tremor _____

PSYCHIATRIC:

Depression _____ Suicidal thoughts _____
Homicidal thoughts _____ Hallucinations _____
Mood changes _____ Anxiety _____
Sleep disturbance _____

ENDOCRINE:

Heat/cool intolerance _____ Hair changes _____
Increased urination _____ Increased thirst _____

HEMATOLOGY:

Anemia _____ Easy bruising _____
Bleeding of skin/gums _____ Swollen glands _____

ALLERGY/IMMUNE SYSTEM:

Frequent infections _____
Breathing difficulties/exposed to allergens _____
Environmental allergies _____

Do you exercise regularly? **Y N** _____

Do you drink alcohol? **Y N** If yes, how many per day? _____ How many per week? _____

Do you currently smoke or have you smoked in the past? If yes, how much? _____ For how long? _____

Thank you for taking time to fill out the forms. Please sign and date:

Patient Signature _____ Date: _____

Physician Signature _____ Date: _____