Welcome to Our Practice

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

Patient Name _____ Date _____

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
Chickenpox	☐ No	☐ Yes	Anemia	☐ No	☐ Yes				Stroke	☐ No	☐ Yes
Pneumonia	☐ No	☐ Yes	Bladder Infections	☐ No	☐ Yes	High or Low	☐ No	☐ Yes	Hepatitis	☐ No	☐ Yes
Rheumatic Fever	☐ No	☐ Yes	Epilepsy	☐ No	☐ Yes	Blood Pressure			Ulcer	☐ No	☐ Yes
Heart Disease	☐ No	☐ Yes	Migraine Headaches	☐ No	☐ Yes	Hemorrhoids	☐ No	☐ Yes	Kidney Disease	☐ No	☐ Yes
Arthritis	☐ No	☐ Yes	Tuberculosis	☐ No	☐ Yes	Asthma	☐ No	☐ Yes	Thyroid Disease	☐ No	☐ Yes
Diabetes	☐ No	☐ Yes	Cancer	☐ No	☐ Yes	Glaucoma	☐ No	☐ Yes	Hernia	☐ No	☐ Yes
Hives or Eczema	☐ No	☐ Yes	AIDS or HIV+	☐ No	☐ Yes	Infections Mono	☐ No	☐ Yes	Bronchitis	☐ No	☐ Yes
Bleeding Tendency	☐ No	☐ Yes	Any Other Disease	☐ No	☐ Yes	Blood Clots	☐ No	☐ Yes			

(please list)_____

Previous Hospitalizations/Surgeries/Serious Illnesses	When	Hospital, City, State/Prov

Medications (include nonprescription):

_____

_____

_____

Allergies to Medications: _____

_____

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: _____			

Family Medical History:

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

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History Update

Name: _____ Birthdate: _____

Today's Date: _____

Thank you for taking the time to answer these questions.

*Most insurance companies require this information to be updated at **every** visit.*

Please check any symptoms which you are currently experiencing

Constitutional
- ☐ Fatigue
- ☐ Weight loss
- ☐ Weight gain

Head, Ears, Nose, Throat
- ☐ Headache
- ☐ Sore throat
- ☐ Decreased hearing

Breast
- ☐ Breast lumps
- ☐ Breast tenderness
- ☐ Nipple discharge

Cardiovascular
- ☐ Chest pain
- ☐ Irregular heartbeat

Respiratory
- ☐ Cough
- ☐ Wheezing
- ☐ Shortness of breath

Gastrointestinal
- ☐ Nausea/vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Abdominal pain

Skin/Hair
- ☐ Rash
- ☐ Skin lesions

Neurologic
- ☐ Seizures
- ☐ Tingling
- ☐ Numbness

Musculoskeletal
- ☐ Joint pain
- ☐ Joint swelling

Endocrine
- ☐ Hair loss
- ☐ Temperature intolerance
- ☐ Abnormal hair growth

Psychiatric
- ☐ Anxiety
- ☐ Depression
- ☐ Difficulty sleeping

When was your last menstrual period?

_____

Have you had any serious illnesses, operations or hospitalizations since your last visit?

_____

Have you discovered any additional information about your family history that we should know?

_____

Have you changed any habits (smoking, drinking, etc.) or occupation since your last visit?

_____

Please list all current medications and doses including herbals and vitamins

_____ _____ _____

_____ _____ _____

Please list any current allergies

_____

Please briefly describe the reason for your visit today

_____

_____