New Patient Information Form

Allergies: ____

MEDICAL PROBLEMS (i.e. high blood pressure, cholesterol, diabetes, asthma, mental illness, etc):

____

____

____

SURGICAL HISTORY (please list **ALL** surgeries **AND COLONOSCOPY** you have had including **YEAR**):

____

____

MEDICATIONS (can skip if brought list or bottles):

Drug	Mg/Strength	How Often	Drug	Mg/Strength	How Often

REASON(s) FOR YOUR VISIT TODAY:

	Reason 1	Reason 2
Explanation		
Frequency of Symptoms		
What makes it better?		

Name:____Date:______________________________

What makes it worse?		
Previous treatment/meds		

REVIEW OF SYSTEMS

Yes or No		Yes or No		Yes or No	
	Recent fever		Asthma or bronchitis		History of STDs
	Weight loss		Shortness of breath		Painful urination
	Changes in vision (glaucoma, cataracts)		Frequent indigestion or heartburn		Frequent bone fracture or muscle sprains
	Hearing loss		Nausea/Vomiting		Changes in skin/mole
	Nasal congestion		Diarrhea		Seizures
	Sinusitis		Constipation		Psychiatric illness
	Sore throat		Bloody or Black Stools		Easy bleeding or bruising
	Chest pains		Blood in urine		Severe allergic reactions

FEMALES ONLY:

Last period: ________________________ Hysterectomy: Yes or No For What reasons: _____________________

Number of pregnancies: ________ Number of children: _________ Last mammogram: ___________ Normal or abnormal

Last PAP: ____________Normal or abnormal History of abnormal PAP: Yes or No

IMMUNIZATIONS (list year received)

Influenza (flu): ______________ Pneumonia: _____________ Tetanus: _____________ Shingles: ___________

SOCIAL HISTORY:

Smoke: Yes or No Packs/day: ______________Previous smoker: Yes or No Packs/day: ___________________

Caffeine Use: Yes or No Amount: _____________ Alcohol use: Yes or No Amount:____________

Current employment: ____

FAMILY HISTORY (place checkmark if family member has condition):

Name:____Date:__________________________________

	Mom	Dad	Sister (s)	Brother (s)	Grandparents (s)
Alive or Dead					
High blood pressure					
High cholesterol					
Diabetes					
Stroke					
Heart Attack					
Cancer (list type)					
Other illness					

Name:____Date:___________________________________