

NEW PATIENT HISTORY

NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

AGE: \_\_\_\_\_ WEIGHT: \_\_\_\_\_ HEIGHT: \_\_\_\_\_ SEX: M \_\_\_\_\_ F \_\_\_\_\_

Occupation: \_\_\_\_\_ Dominant Hand: Right \_\_\_\_\_ Left \_\_\_\_\_

Present Complaint: \_\_\_\_\_

Accident Related ? Y \_\_\_\_\_ N \_\_\_\_\_ If yes: Auto \_\_\_\_\_ Work \_\_\_\_\_ Other \_\_\_\_\_

How? \_\_\_\_\_

When? (date) \_\_\_\_\_ Where? \_\_\_\_\_

Is there an attorney involved: Y \_\_\_\_\_ N \_\_\_\_\_ if yes:

Name: \_\_\_\_\_ Phone number \_\_\_\_\_

Pain Level: Rate it on a scale of 0-10 (0 no pain, 10 worst pain ever) \_\_\_\_\_

Describe it: Constant, intermittent, dull, sharp, aching, burning, shooting (circle one)

How long have you had this pain? \_\_\_\_\_

What makes the pain better? \_\_\_\_\_

What makes the pain worse? \_\_\_\_\_

Have you had a similar problem before? \_\_\_\_\_

What medical tests or treatment have you received for this problem? \_\_\_\_\_

Have you had an MRI or a CT scan for this problem? Y \_\_\_\_\_ N \_\_\_\_\_

What part of body? \_\_\_\_\_ Where was MRI done? \_\_\_\_\_ When? \_\_\_\_\_

List any past surgery: \_\_\_\_\_

Allergies: \_\_\_\_\_

Medications: \_\_\_\_\_

Check any of the following, that to the best of your knowledge, pertain to you:

- |                               |                  |            |
|-------------------------------|------------------|------------|
| _____ Trouble with anesthesia | _____ Bleeding   | _____ PE   |
| _____ Hepatitis               | _____ Clotting   | _____ DVT  |
| _____ Ulcers                  | _____ HIV (AIDS) | _____ NONE |

Do you have a pacemaker? Y \_\_\_\_\_ N \_\_\_\_\_

Name of referring **DOCTOR(s)** \_\_\_\_\_

Patient Name \_\_\_\_\_

**Have you used any of the following substances:** Circle yes or no

Substance:	Current use?		Previous use?		Substance:	Current use?		Previous use?	
Caffeine: coffee, tea, soda:	Yes	No	Yes	No	Tobacco	Yes	No	Yes	No
Alcohol: beer, wine, liquor	Yes	No	Yes	No	Street drugs	Yes	No	Yes	No

**To the best of your knowledge have you or a family member ever been treated for the following:**

Indicate self with an X and which family member has had it by **M**-Mother, **F** -Father, **B** – brother or **S** –sister

_____ Elevated blood pressure	_____ Bleeding	_____ None
_____ Heart disease	_____ Clotting	
_____ Dizziness, fainting or seizure	_____ Parkinson's	
_____ Kidney problems	_____ Cancer, cysts, tumors	
_____ Rheumatism, Arthritis	_____ Stroke	
_____ Diabetes	_____ Osteoporosis	

**General review of system: Circle any symptoms or condition you have had or now have.**

**General:** chills, fatigue, fever, malaise, night sweats, weakness, weight gain/loss \_\_\_\_\_ **None**  
**Cardiovascular:** Chest pain, cyanosis, heart murmur, irregular heartbeat/palpitations, leg swelling, \_\_\_\_\_ **None**  
**Integumentary:** Contact allergy, itchy skin, rash, skin infections, skin lesions \_\_\_\_\_ **None**  
**Metabolic Endocrine:** Cold intolerant, hair loss, heat intolerant \_\_\_\_\_ **None**  
**Ears:** hearing loss, ear drainage, ringing in ears, vertigo (dizziness) \_\_\_\_\_ **None**  
**Nose and sinuses:** facial pain, headache, hoarseness \_\_\_\_\_ **None**  
**Eyes:** Blurred vision, double vision, vision loss \_\_\_\_\_ **None**  
**Neck:** lumps in neck, swollen glands, goiter, pain or stiff neck \_\_\_\_\_ **None**  
**Gastrointestinal:** Abdominal pain, constipation, black tarry stools, diarrhea, heartburn jaundice, loss of appetite, nausea, vomiting \_\_\_\_\_ **None**  
**Neurological:** Difficulty walking, dizziness, poor coordination, memory loss, muscle weakness, paresthesia, seizures, tremors \_\_\_\_\_ **None**  
**Psychiatric:** Anxiety, depression, insomnia, excessive nervousness \_\_\_\_\_ **None**  
**Respiratory:** Chest pain, cough, dyspnea, recent infections, known TB exposure, wheezing \_\_\_\_\_ **None**  
**Genitourinary:** Frequent urination, burning on urination, blood in urine, recurrent bladder or kidney infections, loss of bladder control, kidney stones \_\_\_\_\_ **None**  
**Allergies:** Asthma, bee sting allergies, contact dermatitis, environmental allergies, food allergiges, seasonal allergies \_\_\_\_\_ **None**  
**Male Genital:** drainage from or sores on penis, pain or lump in testicle, prostatitis, scrotal swelling, difficulty in sexual functioning, history of sexually transmitted disease, other \_\_\_\_\_ **None**  
**Female Genital:** Date of last menstrual period \_\_\_\_\_ age at menopause \_\_\_\_\_, complications of pregnancy, drainage from vagina, sores or lumps in or around vagina, abnormal bleeding, difficulty in sexual functioning, history of sexually transmitted disease, other \_\_\_\_\_ **None**  
**Nerve problems:** blackouts, seizures or convulsions, paralysis, frequent or constant numbness or tingling in a body part, abnormal memory loss, tremors, history of polio or muscular sclerosis or stroke/TIA, slurred speech, other \_\_\_\_\_ **None**  
**Blood problems:** anemia, easy bruising or bleeding, splenectomy, leukemia, other \_\_\_\_\_ **None**  
**Other glands:** overactive or under active thyroid, diabetes, excessive urination, sweating or thirst, enlarged lymph nodes, other \_\_\_\_\_ **None**

**Pharmacy:**

Preferred Pharmacy: \_\_\_\_\_

Address and/or Phone number \_\_\_\_\_