NEW PATIENT HISTORY

Account No_____

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: _____

Describe your pain: Constant, intermittent, dull, sharp, aching, burning, shooting (circle all that apply)

How long have you had this pain?_____

Have you fallen in the last year? Y_____ N _____ If yes, how many times? _____

Did the fall(s) result in an injury? Y_____ N_____

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**

Flu Vaccine Y_____ N_____ Date _____ Pneumonia Vaccine Y _____ N _____ Date _____

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
____Heart disease
____Dizziness, fainting or seizure
____Kidney problems
____Rheumatism, Arthritis
____Diabetes

_____Bleeding
_____Clotting
_____Parkinson's
_____Cancer, cysts, tumors
_____Stroke
_____Osteoporosis

____None

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 allergies, seasonal allergies_____ **None**
Male Genital: Drainage from or sores on penis, pain or l ump 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_____