

Date: _____
Patient: _____

New Patient Visit

Ht: _____ Wt: _____
Physician: _____

History:
Chief Complaint: _____

History of present illness:

Location _____ Quality _____
(Where is the pain/problem?) (Example ie swelling, color)

Severity _____ Duration _____
(How severe is the pain/problem?) (How long have you had this problem - date-?)

Timing _____ Context _____
(Does this pain/problem occur at a specific time?) (Where were you at the onset of this pain/problem?)

Associated signs/symptoms _____
(What other associated problems have you been having?)

Modifying factors _____
(What makes the pain/problem worse or better? Have you had previous episodes?)

Medical History

Patient Medical History		
Diabetes.....	No	Yes
Hypertension.....	No	Yes
Cancer.....	No	Yes
Stroke.....	No	Yes
Heart trouble.....	No	Yes
Arthritis/gout.....	No	Yes
Convulsions.....	No	Yes
Bleeding tendency.....	No	Yes
Acute infections.....	No	Yes
Venereal disease.....	No	Yes
Hereditary defects.....	No	Yes

Previous Hospitalization/surgeries/serious injuries	
Describe	Date
_____	_____
_____	_____
_____	_____
_____	_____

Medications		
Name		Dosage
_____		_____
_____		_____
_____		_____
_____		_____

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 _____
Excessive exposure at home or work to: Fumes _____ Dust _____ Solvents _____ Air-born particles _____ Noise _____

Family medical history

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

System Review - To be completed by patient

CONSTITUTIONAL SYMPTOMS

Good general health lately.....No Yes
Recent weight change.....No Yes
Fever.....No Yes
Fatigue.....No Yes
Headaches.....No Yes

EYES

Eye disease or injury.....No Yes
Wear glasses/contact lens.....No Yes
Blurred or double vision.....No Yes
Glaucoma.....No Yes

EARS/NOSE/MOUTH/THROAT

Hearing loss or ringing.....No Yes
Earaches or drainage.....No Yes
Chronic sinus problem or rhinitis.....No Yes
Nose bleeds.....No Yes
Mouth sores.....No Yes
Bleeding gums.....No Yes
Bad breath or bad taste.....No Yes
Sore throat or voice change.....No Yes
Swollen glands in neck.....No Yes

CARDIOVASCULAR

Heart trouble.....No Yes
Chest pain or angina pectoris.....No Yes
Palpitation.....No Yes
Shortness of breath with walking or lying flat.....No Yes
Swelling of feet, ankles or hands.....No Yes

RESPIRATORY

Chronic or frequent coughs.....No Yes
Spitting up blood.....No Yes
Shortness of breath.....No Yes
Asthma or wheezing.....No Yes

GASTROINTESTINAL

Loss of appetite.....No Yes
Change in bowel movements.....No Yes
Nausea or vomiting.....No Yes
Frequent diarrhea.....No Yes
Painful bowel movements or constipation.....No Yes
Rectal bleeding or blood in stool.....No Yes
Abdominal pain or heartburn.....No Yes
Peptic ulcer (stomach or duodenal).....No Yes

GENITOURINARY

Frequent urination.....No Yes
Burning or painful urination.....No Yes
Blood in urine.....No Yes
Change in force of strain when urinating.....No Yes
Incontinence or dribbling.....No Yes
Kidney stones.....No Yes
Sexual difficulty.....No Yes
Male - testicle pain.....No Yes
Female - pain with periods.....No Yes
Female - irregular periods.....No Yes
Female - vaginal discharge.....No Yes
Female - # pregnancies _____ # miscarriages _____
Female - date of last pap smear _____

MUSCULOSKELETAL

Joint pain.....No Yes
Joint stiffness or swelling.....No Yes
Weakness of muscles or joints.....No Yes
Muscle pain or cramps.....No Yes
Back pain.....No Yes
Cold extremes.....No Yes
Difficulty in walking.....No Yes

INTEGUMENTARY (skin, breast)

Rash or itching.....No Yes
Change in skin color.....No Yes
Change in hair or nails.....No Yes
Varicose veins.....No Yes
Breast pain.....No Yes
Breast lump.....No Yes
Breast discharge.....No Yes

NEUROLOGICAL

Frequent or recurring headaches.....No Yes
Light headed or dizzy.....No Yes
Convulsions or seizures.....No Yes
Numbness or tingling sensations.....No Yes
Tremors.....No Yes
Paralysis.....No Yes
Stroke.....No Yes
Head injury.....No Yes

PSYCHIATRIC

Memory loss or confusion.....No Yes
Nervousness.....No Yes
Depression.....No Yes
Insomnia.....No Yes

ENDOCRINE

Glandular or hormone problem.....No Yes
Thyroid disease.....No Yes
Diabetes.....No Yes
Excessive thirst or urination.....No Yes
Heat or cold intolerance.....No Yes
Skin becoming dryer.....No Yes
Change in hat or glove size.....No Yes

HEMATOLOGIC/LYMPHATIC

Slow to heal after cuts.....No Yes
Bleeding or bruising tendency.....No Yes
Anemia.....No Yes
Phlebitis.....No Yes
Past transfusion.....No Yes
Enlarged glands.....No Yes

ALLERGIC/IMMUNOLOGIC

History of skin reaction or other adverse reaction to:
Penicillin or other antibiotics.....No Yes
Morphine, Demerol, or other narcotics.....No Yes
Novocaine or other anesthetics.....No Yes
Aspirin or other pain remedies.....No Yes
Tetanus antitoxin or other serums.....No Yes
Iodine, methiolate or other antiseptic.....No Yes
Other drugs/medications _____
Known food allergies _____