NEW PATIENT INFORMATION FORM

PATIENT NAME: ____ AGE: _____ DATE: ___________

HISTORY

Chief complaint (the reason for the doctor visit today) ____
____

History of Present Illness

*Location ______________________________
____
(Where is the pain/problem?)

*Quality ______________________________
____
(How does it feel?)

*Severity ______________________________
____
(How severe is the pain/problem?)

*Duration ______________________________
____
(How long have you had this pain/problem - when did it start?)

*Timing _ ______________________________
____
(Does this pain/problem occur at a specific time?)

*Context ______________________________
____
(Where were you at the onset of this pain/problem?)

*Associated Symptoms ____________________
____

*Modifying Factors ____________________
____
(What makes the pain/problem worse or better?)

Additional Information ____
____
____
____
____

MEDICAL HISTORY

Patient Medical History

Diabetes	No	Yes
Hypertension	No	Yes
Cancer	No	Yes
CVA/TIA	No	Yes
Pulmonary Disease	No	Yes
Arthritis/Joint Disease	No	Yes
Bleeding Tendency	No	Yes
Stomach Problems	No	Yes
PVD	No	Yes
Peripheral Neuropathy	No	Yes
Depression	No	Yes

Patient Cardiac History

MI	No	Yes
CABG	No	Yes
PTCA	No	Yes
Stent	No	Yes
CHF	No	Yes
Valvular Disease	No	Yes
Pacemaker/AICD	No	Yes
Cardiac Arrest	No	Yes

Menopause Status
[ ] Pre [ ] Peri [ ] Post LMP [ ] HRT

Medications ____
____
____

Patient Personal/Social History

Handedness	[ ] Left	[ ] Right			
Marital Status	[ ] Single	[ ] Married	[ ] Separated	[ ] Divorced	[ ] Widow
Use of Alcohol	[ ] Never	[ ] Rarely	[ ] Moderate	[ ] Daily	
Use of Tobacco	[ ] Never	[ ] Previously, but quit		[ ] Current – Packs/day ____	
Use of Drugs	[ ] Never	[ ] Type/Frequency____________________			

PHYSICAL ACTIVITY ____
____
CAUSES OF STRESS ____
DIET ____

Family Medical History

	Age	Diseases	If deceased, cause of death…
Father	____	______________________	______________________
Mother	____	______________________	______________________

REVIEW OF SYMPTOMS

Constitutional Symptom

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

Cardiovascular

Heart Trouble	No	Yes
Chest Pain/Angina	No	Yes
SOB when walking	No	Yes
Swelling of extremities	No	Yes

Respiratory

Chronic or frequent cough	No	Yes
Shortness of breath	No	Yes
Asthma/Wheezing	No	Yes

Gastrointestinal

Loss of appetite	No	Yes
Change in bowel habits	No	Yes
Nausea or vomiting	No	Yes
Constipation	No	Yes
Abdominal pain/heartburn	No	Yes
Peptic ulcer	No	Yes

Genitourinary

Frequent urination	No	Yes
Burning or painful urination	No	Yes
Blood in urine	No	Yes
Difficulty in starting or stopping	No	Yes
Incontinence	No	Yes
Sexual difficulty	No	Yes
Female-vaginal discharge	No	Yes

Functional

Independent in self care	No	Yes
Dressing Upper body	No	Yes
Dressing lower body	No	Yes
Bathing	No	Yes
Grooming	No	Yes
Eating	No	Yes
Toileting	No	Yes
Independent walking	No	Yes
Independent in climbing stairs	No	Yes
Independent in cooking	No	Yes
Independent in cleaning	No	Yes
Independent in shopping	No	Yes

Musculoskeletal

Joint Pain	No	Yes
Joint stiffness/swelling	No	Yes
Weakness of muscles/joints	No	Yes
Back Pain	No	Yes
Neck pain	No	Yes
Difficulty in walking	No	Yes

Neurological

Frequent or recurring headaches	No	Yes
Lightheaded or dizzy	No	Yes
Convulsions or seizures	No	Yes
Numbness or tingling sensations	No	Yes
Tremors	No	Yes
Paralysis	No	Yes
Head Injury	No	Yes

Psychiatric

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

Endocrine

Glandular or hormone problem	No	Yes
Thyroid disease	No	Yes
Excessive thirst or urination	No	Yes
Heat or cold intolerance	No	Yes

Allergic Immunology

History pf skin reaction or adverse reaction to:

Penicillin or ather antibiotic	No	Yes
Morphine, Demerol, Narcotics	No	Yes
Novacaine or Anesthesia	No	Yes
Aspirin or other pain remedies	No	Yes

Other drugs or foods (list): ____________

____

____

____

____

MD Signature ________________________________ Date ______________