NEW PATIENT MEDICAL HISTORY

Welcome to our Practice! As a new patient, please fill out the information below to the best of your ability.

Physician ______________________ Date____________

Patient name __________________________ Chief complaint ____________________

HISTORY OF PRESENT ILLNESS

Location of pain _______________

Severity __________________
(How severe is pain/problem on a scale from 1-5?)

Timing __________________
(Does this pain/problem occur at a specific time?)

Associated __________________
Signs __________________
Symptoms __________________
(What other associated problems have you been having?)

Quality ______________________
(Example: normal versus abnormal color, activity, etc.?)

Duration ______________________
(How long have you had this pain/problem, or when did it start?)

Context ______________________
(Where were you at the onset of this pain/problem?)

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

PATIENT MEDICAL HISTORY

Have you ever had the following (check no or yes, leave blank if uncertain):

1. Measles No__ Yes __
2. Mumps No__ Yes __
3. Chickenpox No__ Yes __
4. Whooping Cough No__ Yes __
5. Scarlet Fever No__ Yes __
6. Smallpox No__ Yes __
7. Pneumonia No__ Yes __
8. Rheumatic Fever No__ Yes __
9. Heart Disease No__ Yes __
10. Arthritis No__ Yes __
11. Cancer No__ Yes __
12. Polio No__ Yes __
13. Glaucoma No__ Yes __
14. Hernia No__ Yes __
15. Blood or Plasma Transfusion No__ Yes __
16. Back Trouble No__ Yes __
17. High/Low Blood Pressure No__ Yes __
18. Hemorrhoids No__ Yes __
19. Asthma No__ Yes __
20. Hives or Eczema No__ Yes __
21. Venereal Disease No__ Yes __
22. Anemia No__ Yes __
23. Bladder Infection No__ Yes __
24. Epilepsy No__ Yes __
25. Migraine Headaches No__ Yes __
26. Diabetes No__ Yes __
27. AIDS or HIV + No__ Yes __
28. Infectious Mono No__ Yes __
29. Bronchitis No__ Yes __
30. Date of last x-ray ________
31. Mitral Valve Prolapsed No__ Yes __
32. Stroke No__ Yes __
33. Hepatitis No__ Yes __
34. Ulcer No__ Yes __
35. Kidney Disease No__ Yes __
36. Thyroid Disease No__ Yes __
37. Bleeding Tendency No__ Yes __
38. Any Other Disease? ________

Previous Hospitalizations/Surgeries/Serious Illnesses	When	Hospital, City, State

Medications (include non-prescriptions):
____
____

Family Medical History

	Age	Disease	If deceased, cause of death
Father			
Mother			
Sibling's			
Spouse			
Children			

Social History

Marital Status: ·Married ·Single ·Widow
(circle one)

Occupation ______________________

Tobacco Use: ·Yes ·No, If yes how often: ______________________
(circle one)

Alcohol Use: ·Yes ·No, If yes how often: ______________________
(circle one)

Drug Use: ·Yes ·No, If yes please describe: ______________________