NEW PATIENT MEDICAL HISTORY

Name:_____ Acct#:_____ Date:_____

Have you had problems with:

PLEASE EXPLAIN ALL "YES" ANSWERS

			Explanation
Diabetes	No	Yes	If yes, how many years? ____
Cardiovascular			
Heart disease	No	Yes	If yes, how many years? ____
Heart attack	No	Yes	If yes, how many years? ____
High blood pressure	No	Yes	If yes, how many years? ____
Heart surgery	No	Yes	If yes, how many years? ____
High cholesterol	No	Yes	If yes, how many years? ____
Pacemaker	No	Yes	If yes, how many years? ____
Neurologic			
Stroke	No	Yes	_____
TIA	No	Yes	_____
Aneurysm	No	Yes	_____
Respiratory			
Asthma	No	Yes	If yes, how many years? ____
COPD/Emphysema	No	Yes	If yes, how many years? ____
Infectious diseases	No	Yes	If yes, how many years? ____
HIV	No	Yes	If yes, how many years? ____
TB	No	Yes	If yes, how many years? ____
Hepatitis	No	Yes	If yes, which type? _____
Blood disorder			
Anemia	No	Yes	_____
Sickle cell	No	Yes	_____
Leukemia/lymphoma	No	Yes	_____
Other	No	Yes	_____
Stomach, Intestinal	No	Yes	_____
Liver disease	No	Yes	_____
Kidney, bladder, Genital	No	Yes	_____
Bones (joints, muscles, arthritis)	No	Yes	_____
Lymphatics, swollen lymph nodes	No	Yes	_____
Rash, other dermatologic	No	Yes	_____
Psychiatric (depression, other)	No	Yes	_____
Thyroid	No	Yes	_____
Cancer	No	Yes	If yes, what type_____
Fever, weight loss, fatigue	No	Yes	_____
Head (injury, other)	No	Yes	_____
Ears, nose, throat, mouth	No	Yes	_____
Neck (pain, other)	No	Yes	_____
Are you PREGNANT?	No	Yes	Due Date: _____

SYSTEMIC MEDICATIONS (i.e. BY MOUTH, INJECTION, SPRAY)

_____

_____

NEW PATIENT MEDICAL HISTORY

PHARMACY Name , address, telephone :

_____

_____

Are you taking?

Insulin	No	Yes
Aspirin	No	Yes
Coumadin (Warfarin)	No	Yes
Ibuprofen	No	Yes
Vitamin E	No	Yes
Any other blood thinners? (e.g. Plavix)	No	Yes

Allergy History:			**Explanation**
Allergic to any medicines?	**No**	**Yes**	_____
Allergic to iodine or shellfish?	**No**	**Yes**	_____
Allergic to latex?	**No**	**Yes**	_____
Other allergies?	**No**	**Yes**	_____

PLEASE LIST ALL MAJOR ILLNESSES YOU HAVE HAD IN THE PAST AND ALL PREVIOUS SURGERIES AND HOSPITALIZATIONS**: (please note dates if possible)**

_____

_____

_____

Family History:			**Relationship to patient**
Blindness	**No**	**Yes**	_____
Glaucoma	**No**	**Yes**	_____
Heart Disease	**No**	**Yes**	_____
Diabetes	**No**	**Yes**	_____
Cancer	**No**	**Yes**	_____
Other	**No**	**Yes**	_____

Social History: (please circle)

Drug use (noted above?)	**No**	**Yes**	_____	
Smoke?	**Never**	**Former/Quit**	**Current**	
Alcohol?	**None or rare**	**<1drinks/day**	**>1 drinks/day**	
Education?	**High school**	**College**	**Graduate**	
Marital Status	**Single**	**Married**	**Divorced**	**Widowed**
Living Arrangements	**Live alone**	**With spouse**	**With family**	**Other**

Patient Signature:_____ Date:_____

The elements of this history have been confirmed be me and discussed with the patient

_____, D.P.M.

Form Revised 6/9/08