

NEW PATIENT INFORMATION

| | | | |
|------|------|-------------|----------|
| Name | Date | Ht. ft. in. | Wt. lbs. |
|------|------|-------------|----------|

PAST HISTORY

| | | | |
|---|--|--|---|
| Medical Conditions (PLEASE CHECK ALL THAT APPLY NOW OR IN THE PAST) | | | |
| 1 <input type="checkbox"/> Seizure | 8 <input type="checkbox"/> Heart Attack (MI) | 15 <input type="checkbox"/> Emphysema/COPD | 22 <input type="checkbox"/> Enlarged Prostate |
| 2 <input type="checkbox"/> Stroke | 9 <input type="checkbox"/> Diabetes | 16 <input type="checkbox"/> Asthma | 23 <input type="checkbox"/> Sinusitis |
| 3 <input type="checkbox"/> Migraine | 10 <input type="checkbox"/> Low Thyroid | 17 <input type="checkbox"/> Cancer | 24 <input type="checkbox"/> Glaucoma |
| 4 <input type="checkbox"/> Angina | 11 <input type="checkbox"/> High Cholesterol | 18 <input type="checkbox"/> Arthritis (common) | 25 <input type="checkbox"/> Hives |
| 5 <input type="checkbox"/> High Blood Pressure | 12 <input type="checkbox"/> Liver Disease | 19 <input type="checkbox"/> Rheumatoid Arthritis | 26 <input type="checkbox"/> Depression |
| 6 <input type="checkbox"/> Heart Failure | 13 <input type="checkbox"/> GI (Stomach) Bleed | 20 <input type="checkbox"/> Osteoporosis | 27 <input type="checkbox"/> Anxiety |
| 7 <input type="checkbox"/> Atrial Fibrillation | 14 <input type="checkbox"/> Stomach Ulcer | 21 <input type="checkbox"/> Kidney Failure | 28 <input type="checkbox"/> Fibromyalgia |
| Prior Operations | | | |
| 1 <input type="checkbox"/> Heart Bypass | 4 <input type="checkbox"/> Prostate Surgery | 7 <input type="checkbox"/> Cataract Surgery | 10 <input type="checkbox"/> Low Back Surgery |
| 2 <input type="checkbox"/> Heart Stent | 5 <input type="checkbox"/> Heart Valve Surg. | 8 <input type="checkbox"/> Thyroid Surgery | 11 <input type="checkbox"/> Knee Surgery |
| 3 <input type="checkbox"/> Carotid Artery Surg. | 6 <input type="checkbox"/> Pacemaker | 9 <input type="checkbox"/> Neck Spine Surgery | 12 <input type="checkbox"/> Sinus Surgery |
| CURRENT MEDICATIONS | | Additional Medical Conditions | |
| | | | |
| | | | |
| | | Additional Prior Operations | |
| | | | |
| MEDICATION ALLERGIES | | Major Injuries | |
| | | | |

FAMILY MEDICAL HISTORY

| | Age (yrs) | Diseases | If Deceased, Cause of Death |
|---|--|--|---|
| Father | | | |
| Mother | | | |
| Sibling | | | |
| | | | |
| Child | | | |
| | | | |
| Family History (PLEASE CHECK ALL THAT APPLY NOW OR IN THE PAST) | | | |
| <input type="checkbox"/> Migraine | <input type="checkbox"/> Parkinson's Disease | <input type="checkbox"/> Alzheimer's Disease | <input type="checkbox"/> Tremor/Not Parkinson's |
| <input type="checkbox"/> Other Neurological (Nervous System) Conditions or Diseases : | | | |

PATIENT SOCIAL HISTORY

| | |
|---|--|
| Occupation : | Retired: <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Marital Status : | <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widow |
| Tobacco Smoking : | <input type="checkbox"/> Never <input type="checkbox"/> Quit (date :) <input type="checkbox"/> Current Smoker : (packs/d=) |
| Use of Alcohol : | <input type="checkbox"/> Never <input type="checkbox"/> Occasional <input type="checkbox"/> Moderate (1-2/day) <input type="checkbox"/> 3 or more/day |
| Drug Abuse (current or in the past) : | |
| Highest Education Level : | |

REVIEW OF SYSTEMS (PLEASE CHECK ALL THAT APPLY NOW OR IN THE PAST)

| | | | |
|---|---|--|--|
| 1 <input type="checkbox"/> Fever (recent) | 8 <input type="checkbox"/> Irregular Heartbeat | 15 <input type="checkbox"/> Frequent Urination | 22 <input type="checkbox"/> Depression |
| 2 <input type="checkbox"/> Severe Weight Loss | 9 <input type="checkbox"/> Cough | 16 <input type="checkbox"/> Painful Urination | 23 <input type="checkbox"/> Excessive Thirst |
| 3 <input type="checkbox"/> Blurry Vision | 10 <input type="checkbox"/> Shortness of Breath | 17 <input type="checkbox"/> Joint Pain | 24 <input type="checkbox"/> Excessive Sweating |
| 4 <input type="checkbox"/> Eye Pain | 11 <input type="checkbox"/> Jaundice | 18 <input type="checkbox"/> Muscle Pain | 25 <input type="checkbox"/> Excessive Bleeding |
| 5 <input type="checkbox"/> Hearing Loss | 12 <input type="checkbox"/> Nausea | 19 <input type="checkbox"/> Skin Rash | 26 <input type="checkbox"/> Excessive Bruising |
| 6 <input type="checkbox"/> Ringing / Noise In Ear | 13 <input type="checkbox"/> Reflux | 20 <input type="checkbox"/> Itching | |
| 7 <input type="checkbox"/> Chest Pain | 14 <input type="checkbox"/> Urine Incontinence | 21 <input type="checkbox"/> Anxiety | |