

NEW PATIENT INFORMATION

Name	Date	Ht. ft. in.	Wt. lbs.
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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
Additional Medical Conditions		Current Medications	
Additional Prior Operations			
Major Injuries		Medication Allergies	

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"/> Other Neurological (Nervous System) Conditions or Diseases :		<input type="checkbox"/> Tremor/Not Parkinson's	

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	