



New Patient Medical History Questionnaire

Please complete this form to provide the doctor with a comprehensive review of your medical/ surgical, social and family history.

What is reason for today's visit? _____

REVIEW OF SYSTEMS:	Do you have - or have you recently had - any of the following?	No	Yes
Genitourinary	Trouble starting to urinate		
	Frequent urination		
	Blood in urine		
	Urinary tract infection		
	Burning on urination		
	Loss of urine (leaking)		
	Sexually Transmitted Disease		
Constitutional	Fever or Chills		
	Weight loss or gain		
Eyes	Glaucoma		
Ears / Nose / Throat	Trouble swallowing		
	Hearing Loss		
	Vertigo (feeling dizzy)		
Nervous System	Have you ever passed out or fainted?		
	Numbness or tingling in your arms or legs		
	Headaches		
	Blurred vision		
	Shakiness when walking		
Cardiovascular	Chest pain		
	Swelling in your ankles / feet		
	Heart skipping / pounding		
	Neck, jaw or arm pain that may be related to your heart		
	Cramping or tightness in your legs when walking		
Respiratory	Shortness of breath		
	Wheezing		
	Coughing up blood		
Gastrointestinal	Constipation or diarrhea		
	Nausea or vomiting		
	Do you have a history of ulcers?		
	Bleeding from your rectum or vomiting blood		
Musculoskeletal	Joint aches, muscle aches or arthritis, back pain		
Skin	Skin rashes		
Hematologic / Lymphatic	Painful or swollen glands		
	Do you bruise easily?		
Psychiatric	Do you have a history of depression or other psychiatric illness?		



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MEDICAL / SURGICAL HISTORY:	No	Yes	If Yes, explain here
Heart Disease / Angina / Chest Pain			
High Blood Pressure			
High Cholesterol			
Heart Valve Disease / Heart Murmurs			
Heart Arrhythmias / Atrial Fibrillation			
Diabetes			
Poor Leg Circulation / Blood Clots			
Kidney Disease			
Stroke / TIA (Transient Ischemic Attack) / Mini-stroke			
Seizures / Epilepsy / Parkinson's / Multiple Sclerosis			
Asthma / Hay Fever			
Pneumonia / Bronchitis			
Emphysema			
HIV or AIDS			
Hepatitis / Liver Disease			
Thyroid Disease			
Anemia (Low Iron) / Blood Transfusions			
Stomach Ulcers / Acid Reflux			
Cancer (Type: _____)			
Depression / Anxiety / Psychiatric Condition			
Surgeries			
Number of Pregnancies: _____ <input type="checkbox"/> N/A	Number of Live births: _____ <input type="checkbox"/> N/A		

Allergies:

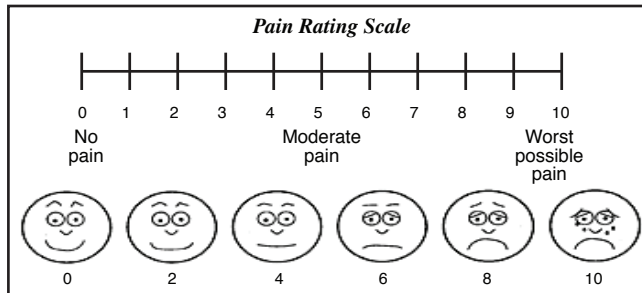
Please list current medications:

_____	_____
_____	_____
_____	_____
_____	_____



PAIN Level (How bad is the pain?): 0 2 4 6 8 10

Location (Where do you hurt?): _____



SOCIAL HISTORY:

Are you: Single Divorced Married Widow / Widower

Who lives with you? _____

Are you working now? No Yes Occupation: _____ Employer: _____

Do you smoke? No Yes How many packs per day: _____ For how many years: _____

Did you smoke in the past? No Yes Year that you quit: _____

Do you drink alcohol? No Yes How much per day: _____ per week: _____ per month: _____

Do you use recreational drugs? No Yes What kind? _____

FAMILY HISTORY:

Has anyone in your immediate family had the following?	No	Yes	What is the health of your:
High blood pressure			Mother: _____
Diabetes			Father: _____
Heart disease (heart attack, sudden death, heart failure)			Brother(s): _____
Stroke			Sister(s): _____

Patient Certification: I have answered these questions the best of my ability. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to tell the doctor's office of any changes in my medical status.

X _____ Patient's Signature _____ Print Name _____ **OR**

X _____ Signature of Person authorized to sign for patient _____ Print Name _____ and _____ Relationship to patient

Date: ___/___/___ Time: ___:___:___ a.m. p.m.

Physician Review: I have reviewed this information with the patient and/or the patient's representative.

X _____ M.D. _____ Print Name _____ M.D. ___/___/___ Date _____ Time (24 hour)