New Patient Information Form

Date: _____

Name: _____ DOB: _____

CC (chief complaint)/ HPI

What is the reason for your visit? _____
Location: Where is the pain/problem? _____
Severity: How severe is the pain/problem? 1 2 3 4 5 6 7 8 9 10
Timing: Does the pain/problem occur at a specific time? Yes/No
Quality: (Example: if coughing, color of sputum) _____
Duration: How long have you had this pain/problem? When did it start? _____
Context: Where were you at the onset of this pain/problem? _____
Modifying factors: What make the pain/problem worse or better? _____ Any previous episodes? _____

Medical History:

Diabetes:	Y/N	
Hypertension:	Y/N	
Cancer:	Y/N	comment _____
Stroke:	Y/N	
Heart Trouble:	Y/N	comment _____
Arthritis/gout:	Y/N	
Convulsions:	Y/N	
Bleeding tendency:	Y/N	
Acute infections:	Y/N	comment_____
Venereal Disease:	Y/N	comment_____
Hereditary defects:	Y/N	comment_____

Allergies:

Drug Allergies: Y/N If so, what kind? _____
Food Allergies: Y/N If so, what kind? _____
Environmental: Y/N If so, what kind? _____

Hobbies:

_____
_____

Animals/Pets:

_____
_____

Family History:

		What family member?	
Asthma:	Y/N	Father __ Mother__ Sister ___ Brother ___	
COPD:	Y/N	Father __ Mother__ Sister ___ Brother ___	
Cancer:	Y/N	Father __ Mother__ Sister ___ Brother ___	What type: _____
Hypertension:	Y/N	Father __ Mother__ Sister ___ Brother ___	
Any other lung disease:	Y/N	Father __ Mother__ Sister ___ Brother ___	What type: _____

Social History:

Use of alcohol: __Never __Rarely __Moderate __Daily
Use of Tobacco: __Never __Previously, but Quit __Currently __packs/day
Use of Drugs: __Never __Type/Frequency
Excessive Exposure at home or work to: __Fumes __Dust __Solvents __Air-borne particles __Noise

Surgeries

List any past medical surgeries and dates procedures were done.

_____
_____
_____
_____

Constitutional Symptoms

Good general health lately	Y/N
Recent weight change	Y/N
Fever	Y/N
Fatigue	Y/N
Headaches	Y/N

Eyes

Eye disease or injury	Y/N
Wear glasses/contact lenses	Y/N
Blurred or double vision	Y/N
Glaucoma	Y/N

Ear/Nose/Mouth/Throat

Hearing loss or ringing	Y/N
Earaches or drainage	Y/N
Chronic sinus problems or rhinitis	Y/N
Nose bleeds	Y/N
Mouth Sores	Y/N
Bleeding Gums	Y/N
Bad breath or bad taste	Y/N
Sore throat or voice change	Y/N
Swollen glands in neck	Y/N

Cardiovascular

Heart trouble	Y/N
Chest pain or angina pectoris	Y/N
Palpitations	Y/N
Shortness of breath with walking	Y/N
Shortness of breath with lying flat	Y/N
Swelling of feet, ankles or hands	Y/N

Gastrointestinal

Loss of appetite	Y/N
Change in bowel movements	Y/N
Nausea or vomiting	Y/N
Frequent diarrhea	Y/N
Painful bowel movements	Y/N
Constipation	Y/N
Rectal Bleeding or blood in stool	Y/N
Abdominal pain or heartburn	Y/N
Peptic ulcer (stomach or duodenal)	Y/N

Genitourinary

Frequent urination	Y/N
Burning or painful urination	Y/N
Blood in urine	Y/N
Change in force of strain w/ urination	Y/N
Incontinence or dribbling	Y/N
Kidney stones	Y/N
Sexual difficulty	Y/N

Female Patients:

Pain with periods	Y/N
Irregular periods	Y/N
Vaginal discharge	Y/N

Pregnancies___ # miscarriages ___

Last pap smear _____

Age of Menarche: ____

Age of first pregnancy____

Last menstrual period____

Musculoskeletal

Joint pain	Y/N
Joint stiffness or selling	Y/N
Weakness of muscles or Joints	Y/N
Muscle pain or cramps	Y/N
Back pain	Y/N
Cold extremities	Y/N
Difficulty in walking	Y/N

Integumentary (skin and breast)

Rash or itching	Y/N
Change in skin color	Y/N
Change in hair or nails	Y/N
Varicose veins	Y/N
Breast pain	Y/N
Breast lump	Y/N
Breast discharge	Y/N

Psychiatric

Memory loss	Y/N
Confusion	Y/N
Nervousness	Y/N
Depression	Y/N
Insomnia	Y/N

Neurological

Frequent or recurring headaches	Y/N
Light headed or dizzy	Y/N
Convulsions or seizures	Y/N
Numbness or tingling sensations	Y/N
Tremors	Y/N
Paralysis	Y/N
Stroke	Y/N
Head Injury	Y/N

Endocrine

Glandular or hormone problem	Y/N
Thyroid disease	Y/N
Diabetes	Y/N
Excessive thirst or urination	Y/N
Heat or cold intolerance	Y/N
Skin becoming dryer	Y/N
Change in hat or glove size	Y/N

Hematologic/Lymphatic	Y/N
Slow to heal after cuts	Y/N
Bleeding or bruising tendency	Y/N
Anemia	Y/N
Phlebitis	Y/N
Past transfusion	Y/N
Enlarged glands	Y/N

Allergic/Immunologic

History of skin reaction or other adverse reaction to:

Penicillin or other antibiotics	Y/N
Morphine, Demerol or other narcotics	Y/N
Novocain or other anesthetics	Y/N
Aspirin or other pain remedies	Y/N
Tetanus	Y/N
Antitoxin or other serums	Y/N
Iodine, methiolate, or other antiseptic	

Other Drugs/medication _____

Known food allergies _____

Sleep History:

Snoring:	Y/N
Insomnia:	Y/N
Hypersomnia:	Y/N
Sleepwalking:	Y/N
Sleep Talking:	Y/N
Bruxism:	Y/N
Restless Leg:	Y/N
Sleep Apnea:	Y/N
Nighttime Urination:	Y/N

Respiratory:

TB:	Y/N
Wheezing:	Y/N
Asthma:	Y/N
Pneumonia:	Y/N
Blood Clots:	Y/N
Bronchitis:	Y/N
Emphysema:	Y/N
Dyspnea:	Y/N
Pleurisy:	Y/N
Cough:	Y/N
Asbestosis:	Y/N
Chest Pain:	Y/N
Effusions:	Y/N
TB Skin Test:	Y/N
Black Lung:	Y/N
Chronic or Frequent Coughs:	Y/N
Spitting up blood:	Y/N
Shortness of Breath:	Y/N
Wheezing:	Y/N