New Patient History Form **Date:**________________

Name:________________________________ Age:______ Date of Birth: / / Sex: M F
M D Y

Chief Complaint: ____

PAST MEDICAL HISTORY
Have you ever had any of the following:

Check each item	No	Yes	Check each item	No	Yes	Check each item	No	Yes
Anemia			Emphysema			Pacemaker		
Anxiety			Gallstones			Phlebitis		
Arthritis			Heart attack			Pneumonia		
Asthma			Hepatitis			Seizure		
Back disorder			High blood pressure			Stomach ulcer		
Blood clot			Kidney infection			Stroke		
Cancer			Kidney stone			Thyroid trouble		
Coronary artery disease			Liver disease			Tuberculosis		
Depression			Lupus			Other		
Diabetes			Mitral valve prolapse					

Your hospitalizations: ☐None Year Hospital

Illnesses (kind): ______________________________ ________ ______________________
______________________________ ________ ______________________
______________________________ ________ ______________________

Surgery (kind): ______________________________ ________ ______________________
______________________________ ________ ______________________
______________________________ ________ ______________________

Have you ever had a bone density test? ☐No ☐Yes If yes, when? ______________________

List Present Medications:

Name	Strength	How Often Taken
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

List All Medication Allergies:

Medication	Reaction
1.	
2.	
3,	
4.	
5.	

Please check if you have an allergy to: ☐ Eggs ☐Iodine ☐Shellfish

Please list any food allergies:____

FAMILY HISTORY
Do you have a family history of:

	No	Yes	Family Member		No	Yes	Family Member
Anesthesia problems				High Blood Pressure			
Bleeding problems				Osteoporosis			
Cancer (location)				Stroke			
Diabetes				Thyroid Disease			
Heart disease				Other Disease			

SOCIAL HISTORY
Occupation:______________________________ ☐ Retired ☐Disabled ☐Unemployed

Marital Status: ☐Single ☐Married ☐Separated ☐Divorced ☐Widowed

Number of children: _________ Hobbies:________________________________

Your personal habits: Do you…..

	No	Yes
Regularly exercise (3-4 times a week)		
Wear auto seat belts (90% of the time)		
Use illegal drugs		
Use alcohol		
Smoke (if ever, when did you stop?_________)		

Are you ☐ right handed ☐left handed

Are you or have you ever been under pain management care? ☐ No ☐Yes (☐Currently ☐ In the past)
Pain management facility: ____

REVIEW OF YOUR BODY SYSTEMS: Do you have any of the following now?

	No	Yes
Unexplained fever		
Unexplained weight loss		
Recent weight gain		
Fatigue		
Vision changes		
Hearing problems		
Neck pain		
Neck swelling		
Shortness of breath		
Coughing blood		
Chest pain		
Irregular heart beat		
Stomach pain		
Heartburn		
Diarrhea		
Constipation		
Stool changes		
Urinary frequency/burning		
Blood in urine		
Swollen or painful joints		
Blackouts or seizures		
Anxiety		
Depression		
Yellow skin		
Skin lesions or ulcers		