NEW PATIENT INFORMATION FORM

Date:	Document at least 3 Sitting BP ____/_____ Height _______ Standing BP ____/_____ Weight ______ Supine BP ____/_____ Temp. _______ Heart rate __________ Resp. rate _____
Patient:	
Referred by:	

HISTORY

CHIEF COMPLAINT/ HISTORY OF PRESENT ILLNESS

For an "extended" history, document 4+ elements

- Location (Where is the pain/problem?)
- Severity (How severe is the pain/problem?)
- Timing (Does the pain/problem occur at a specific time?)
- Associated signs/symptoms
- Quality (Example: color of sputum)
- Duration (How long have you had this pain/problem? Or When did it start?)
- Context (Where were you at the onset of this pain/problem?)
- Modifying factors (What makes it worse or better? Or Any previous episodes?)

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MEDICAL HISTORY

For a "pertinent" history, at least 1 specific item for ANY ONE of the 3 histories

For a "complete" history, at least 1 specific item for EACH ONE of the 3 histories

Patient MEDICAL history

Diabetes	No	Yes
Hypertension	No	Yes
Cancer	No	Yes
Stroke	No	Yes
Heart trouble	No	Yes
Arthritis/gout	No	Yes
Convulsions	No	Yes
Bleeding tendency	No	Yes
Acute infections	No	Yes
Venereal disease	No	Yes
Hereditary defects	No	Yes

Previous Hospitalizations/Surgeries/Serious Injuries	When?
____	_________________
____	_________________
____	_________________
____	_________________

FAMILY medical history

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Patient SOCIAL history

Marital status: ___single ___married ___separated ___divorced ___widowed

Use of alcohol: ___never ___rarely ___moderate ___daily

Use of tobacco: ___never ___previously, but quit Current packs/day_________________

Use of drugs: ___never Type/Frequency ____

Excessive exposure at home or work to: ___fumes ___dust ___solvents ___air-borne particles ___noise

Medications

1) ____
2) ____
3) ____
4) ____
5) ____
6) ____
7) ____
8) ____
9) ____
10) ____
11) ____
12) ____

REVIEW OF SYSTEMS

CONSTITUTIONAL SYMPTOMS
Good general health ………………...................... No Yes
Recent weight change………………..................... No Yes
Fever……………………………….................. No Yes
Fatigue………………………………............... No Yes
Headaches…………………………................. No Yes

EYES
Eye disease or injury…………………................. No Yes
Wear glasses/contact lenses…………................... No Yes
Blurred or double vision……………...............… No Yes
Glaucoma…………………………................. No Yes

EARS/NOSE/MOUTH/THROAT
Hearing loss or ringing………………................... No Yes
Earaches or drainage…………………................. No Yes
Chronic sinus problem or rhinitis……..................... No Yes
Nose bleeds……………………….................... No Yes
Mouth sores……………………..............…..... No Yes
Bleeding gums…………………….................… No Yes
Bad breath or bad taste……………...............….... No Yes
Sore throat or voice change…………...............…. No Yes
Swollen glands in neck………………................. No Yes

CARDIOVASCULAR
Heart trouble………………………................... No Yes
Chest pain or angina pectoris……….............…..... No Yes
Palpitation…………………………......…......... No Yes
Shortness of breath with walking or lying flat........ No Yes
Swelling of feet, ankles or hands……....…........... No Yes

RESPIRATORY
Chronic or frequent coughs…………....…....….... No Yes
Spitting up blood……………………....…....….... No Yes
Shortness of breath…………………....…....…..... No Yes
Asthma or wheezing…………………....…........... No Yes

GASTROINTESTINAL
Loss of appetite……………………....…....….... No Yes
Change in bowel movements………....…....…….. No Yes
Nausea or vomiting…………………....…....…… No Yes
Frequent Diarrhea…………………....…....….... No Yes
Painful bowel movements or
constipation……………………………....…....…. No Yes
Rectal bleeding or blood in stool……….....…....… No Yes
Abdominal pain or heartburn…………....…....….... No Yes
Peptic ulcer (stomach or duodenal)……....…....…. No Yes

GENITOURINARY
Frequent urination……………………......…..….. No Yes
Burning or painful urination…………...…....…….. No Yes
Blood in urine……………………………...…….. No Yes
Change in force of strain when urinating…….…..... No Yes
Incontinence or dribbling…………….….....……. No Yes
Kidney stones……………………….…....…….. No Yes
Sexual difficulty…………………….….....…….. No Yes
Male - testicle pain……………………....….…….. No Yes
Female - irregular periods……………...….......… No Yes
Female - vaginal discharge…………….......……... No Yes
Female - #pregnancies______ #miscarriages________
Female - date of last pap smear _____/_____/________
Female - age of menarche ____________
Female - age of first pregnancy __________
Female - last menstrual period _____/_____/________

MUSCULOSKELETAL
Joint pain…………………………………………….. No Yes
Joint stiffness or swelling……………………………. No Yes
Weakness of muscles or joints………………………. No Yes
Muscle pain or cramps………………………………. No Yes
Back pain…………………………………………. No Yes
Cold extremities ………………………………….. No Yes
Difficulty in walking……………………………… No Yes

INTEGUMENTARY (skin, breast)
Rash or itching………………………………………. No Yes
Change in skin color………………………………… No Yes
Change in hair or nails………………………………. No Yes
Varicose veins……………………………………….. No Yes
Breast pain…………………………………………… No Yes
Breast lump………………………………………….. No Yes
Breast discharge……………………………………... No Yes

NEUROLOGICAL
Frequent or recurring headaches…………………….. No Yes
Light headed or dizzy……………………………….. No Yes
Convulsions or seizures……………………………… No Yes
Numbness or tingling sensations……………………. No Yes
Tremors……………………………………………… No Yes
Paralysis……………………………………………... No Yes
Stroke………………………………………………… No Yes
Head injury…………………………………………... No Yes

PSYCHIATRIC
Memory loss or confusion…………………………… No Yes
Nervousness……………………………………….. No Yes
Depression…………………………………………… No Yes
Insomnia .... No Yes

ENDOCRINE
Glandular or hormone problem……………………… No Yes
Thyroid disease……………………………………… No Yes
Diabetes……………………………………………… No Yes
Excessive thirst or urination…………………………. No Yes
Heat or cold intolerance……………………………... No Yes
Skin becoming dryer………………………………… No Yes
Change in hat or glove size………………………….. No Yes

HEMATOLOGIC/LYMPHATIC
Slow to heal after cuts……………………………….. No Yes
Bleeding or bruising tendency………………………. No Yes
Anemia……………………………………………….. No Yes
Phlebitis……………………………………………… No Yes
Past transfusion……………………………………… No Yes
Enlarged glands……………………………………… No Yes

ALLERGIC/IMMUNOLOGIC
History of skin reaction or other adverse reaction to:
Penicillin or other antibiotics………………………... No Yes
Morphine, Demerol, or other narcotics……………… No Yes
Novocaine or other anesthetics……………………… No Yes
Aspirin or other pain remedies……………………… No Yes
Tetanus antitoxin or other serums…………………… No Yes
Iodine, methiolate or other antiseptic……………….. No Yes
Other drugs/medications__________________________
____
Known food allergies____________________________
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ADDITIONAL COMMENTS: ____

PHYSICIAN: ____ DATE: ___________________________