



NEW PATIENT HISTORY FORM

TODAY'S DATE ___/___/___ DATE OF BIRTH: ___/___/___ AGE:___ HT. ___ WT. ___
LAST NAME _____ FIRST NAME: _____ MI:___

CHIEF COMPLAINT: What is the main reason for your visit today? _____

HISTORY OF PRESENT ILLNESS

Date of Accident or Date Symptoms Began:
___/___/___

Location of the problem: R L Both
Area: _____

- Was this a work-related accident? Yes No
Was this an auto accident? Yes No
Recreational or school athletic injury? Yes No
Accident in your home? Yes No
Accident other than above? Yes No

Explain: _____

Are you currently working? Yes No N/A
If yes, are you working: full duty or limited duty
Occupation: _____

Explain Injury or Problem: _____

Describe the symptoms you are having: _____

Are the symptoms/problem constant or variable?
Dull then Sharp Very sharp then leaves Constant
Other _____

How long do the symptoms/problem last?
Seconds Minutes Hours Always present
Other _____

Does anything make the symptoms/problem worse?

Does anything make the symptoms/problem better?

Is anything else occurring at the same time?
Yes No If yes, please explain.

List any other doctors you have seen for this problem.

List any previous tests or procedures for this problem.

Does the problem interfere with your normal functions?
Yes No If yes, please explain

PAST MEDICAL, FAMILY & SOCIAL HISTORY

List any personal illness and medical condition for which you are treated. (current and past)

List any surgeries and date occurred.

List all serious illnesses in your immediate family.
(Example: blood clots, diabetes, cancer, heart disease, etc..) Relation

Do you have any drug allergies?
Yes No (If Yes, please explain)
Drug Reaction

Please list all medications you are currently taking.

Do/did you smoke? Yes No
 If yes, how much? _____
 If yes, how long? _____

Do/did you drink alcohol? Yes No
 If yes, how much? _____

Are you right or left handed?
 R L

Do you exercise regularly? Yes No
 If yes, how much? _____
 What exercises: _____

If age 55 or older, have you ever had a Bone Density Test?
 Yes No

REVIEW OF SYSTEMS

Do you now or have you had any problems related to the following systems? Circle Yes or No.

Constitutional Symptoms

Fever Y N
 Chills Y N
 Headache Y N
 Change in appetite, wt, energy Y N
 Other _____

Integumentary

Skin rash Y N
 Boils Y N
 Persistent itch Y N
 Other _____

Eyes

Blurred vision Y N
 Double vision Y N
 Pain Y N
 Other _____

Musculoskeletal

Neck pain Y N
 Joint swelling/pain Y N
 Back pain Y N
 Bone pain Y N
 Other _____

Allergic/Immunologic

Hay Fever Y N
 Drug allergies Y N
 Food allergies Y N

Other

Ear/Nose/Throat/Mouth

Ear infection Y N
 Sore throat Y N
 Sinus problem Y N
 Bleeding ears, nose, gums Y N
 Other _____

Neurological

Tremors Y N
 Dizzy spells/ Y N
 Numbness/tingling Y N
 Seizures Y N
 Other _____

Genitourinary

Urine retention Y N
 Painful urination Y N
 Urinary frequency Y N
 Change in urine stream Y N
 Other _____

Endocrine

Excessive thirst Y N
 Too hot/cold Y N
 Tired/sluggish Y N
 Other _____

Respiratory

Wheezing Y N
 Frequent cough Y N
 Shortness of breath Y N
 Other _____

Gastrointestinal

Abdominal pain Y N
 Nausea/vomiting Y N
 Indigestion/heartburn Y N
 Change stool size/shape/color Y N
 Pain with swallowing Y N
 Hepatitis Y N
 Other _____

Hematologic/Lymphatic

Swollen glands Y N
 Blood clotting problem Y N
 On blood thinners Y N
 Prior blood transfusions Y N
 HIV Y N
 Other _____

Cardiovascular

Chest pain Y N
 Rapid heart rate Y N
 Slow heart rate Y N
 Pacemaker Y N
 High blood pressure Y N
 Other _____

How long did it take to get an appointment: _____ 1 day _____ days _____ 1 week _____ weeks

List any problems or difficulties you have had in scheduling your visit with us. _____

