



New Patient Evaluation

Dear New Patient,

Date: _____

Welcome to our practice. Please fill out the information to the best of your ability.

Name: _____ Date of Birth: _____ Sex: M / F

Diagnosis/Reason for your visit : _____

Referring Physician: _____ Family Physician: _____

Please list all other Physicians that you would like to have a copy of your medical information:

Pharmacy you typically use(name,city,state,phone): _____

Preferred Language: _____ Race: _____ Ethnicity: _____

CURRENT MEDICATIONS (Including over the counter, dose and frequency):

1.) _____ 5.) _____

2.) _____ 6.) _____

3.) _____ 7.) _____

4.) _____ 8.) _____

ALLERGIES (Including adverse reaction if known): _____

SOCIAL HISTORY

Marital Status: () Single () Married () Separated () Divorced () Widowed

Occupation _____ Retired? Yes / No

Exposure to Hazardous Materials? Yes / No () Asbestos () Benzene () Lead () Radiation Other _____

Alcohol Use: () Never () Rare () Moderate () Daily # _____ drinks per day / week

Tobacco Use: () Never () Quit ___ months / years () Current Smoker # _____ packs per day # _____ year(s)

() Cigarettes () Cigars () Chewing Tobacco () Pipe () Recreational Drug Use _____

Please indicate your activity level: () Sedentary () Daily Activities () Exercise Occasional / Regular / Extensive

Name: _____

PAST MEDICAL HISTORY

- | | | |
|---|--|--|
| <input type="checkbox"/> Aids or HIV+ | <input type="checkbox"/> Diverticulitis | <input type="checkbox"/> Mitral Valve Prolapse |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Diverticulosis | <input type="checkbox"/> Myocardial Infarction |
| <input type="checkbox"/> Alzheimers | <input type="checkbox"/> Drug Dependency | <input type="checkbox"/> Obesity |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Elevated Cholesterol | <input type="checkbox"/> Osteoarthritis |
| <input type="checkbox"/> Anorexia | <input type="checkbox"/> Endocarditis | <input type="checkbox"/> Osteopenia |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Endometriosis | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Arteriovenous Malormations | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Pancreatitis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Gallstones | <input type="checkbox"/> Peripheral Neuropathy |
| <input type="checkbox"/> Atrial Fibrillation | <input type="checkbox"/> GERD | <input type="checkbox"/> Peripheral Vascular Disease |
| <input type="checkbox"/> Autoimmune Disease | <input type="checkbox"/> Gout | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Benign Prostatic Hypertrophy | <input type="checkbox"/> Hearing Loss | <input type="checkbox"/> Seizure |
| <input type="checkbox"/> Bleeding/Clotting Disorder | <input type="checkbox"/> Hemochromatosis | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Blood Pressure High / Low | <input type="checkbox"/> Hepatitis A / B / C | <input type="checkbox"/> Thalassemia |
| <input type="checkbox"/> Cancer Type: _____ | <input type="checkbox"/> Hyperlipidemia | <input type="checkbox"/> Thrombocytopenia |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Thrombocytosis |
| <input type="checkbox"/> Chrons Disease | <input type="checkbox"/> Hyperthyroidism | <input type="checkbox"/> TIA |
| <input type="checkbox"/> COPD | <input type="checkbox"/> Hypotension | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Congenital Heart Defects | <input type="checkbox"/> Hypothyroidism | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Congestive Heart Failure | <input type="checkbox"/> Irritable Bowel Syndrome | <input type="checkbox"/> Vertigo |
| <input type="checkbox"/> Coronary Artery Disease | <input type="checkbox"/> Kidney Stones | <input type="checkbox"/> Vision Loss |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Manic Depressive Disorder | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Diabetes Type 1 / 2 | <input type="checkbox"/> Migraines | <input type="checkbox"/> _____ |

PAST SURGICAL HISTORY Please list all surgeries/procedures including date(s)

FAMILY HISTORY

Is there any family History of Cancer? Yes / No Please specify the type and relative affected:

If your family has a history of any of the following indicate the family member by : 'M'other 'F'ather 'S'ister 'B'rother

- | | | |
|--|---|--|
| <input type="checkbox"/> Alcoholism_____ | <input type="checkbox"/> Heart Disease_____ | <input type="checkbox"/> Obesity_____ |
| <input type="checkbox"/> Blood Clots_____ | <input type="checkbox"/> Hemochromatosis_____ | <input type="checkbox"/> Seizure Disorder_____ |
| <input type="checkbox"/> Bleeding Disorders_____ | <input type="checkbox"/> High Blood Pressure_____ | <input type="checkbox"/> Stroke_____ |
| <input type="checkbox"/> Depression_____ | <input type="checkbox"/> Kidney Problems_____ | Other:_____ |
| <input type="checkbox"/> Diabetes_____ | <input type="checkbox"/> Manic Depressive Disorder_____ | _____ |

GYNECOLOGICAL HISTORY (WOMEN ONLY)

Are you or could you be Pregnant? Yes / No

Age that Periods began:_____ Date of last Menstrual Period:_____ Age at Menopause:_____

Number of Pregnancies #_____ Number of Births #_____ Number of Interrupted Pregnancies #_____

Age at first birth:_____ Are you using Hormonal Contraceptives: Yes / No If YES, #_____ of years

Have you ever used: Birth Control Pills Fertility Drugs Hormone Replacement after Menopause

ROUTINE HEALTH MAINTENANCE

List if and when you had the following health maintenance testing done:

- Colonoscopy When was most recent: _____
- Mammogram When was most recent: _____
- Pap Smear When was most recent: _____
- PSA Blood test When was most recent: _____

Name: _____

REVIEW OF SYSTEMS (Please circle any that apply)

GENERAL INFORMATION

- Recent weight change
 - Gain or Loss
- Loss of appetite
- Persistent fevers
- Night sweats
- Enlarged lymph nodes

NEUROLOGIC

- Headaches
- Dizziness/ Blackouts
- Seizures
- Numbness or tingling
- Weakness or paralysis
- Visual problems
- Hearing problems

CHEST

- Pain
- Shortness of breath
- Cough
- Coughing up blood

MOUTH/ THROAT

- Pain or soreness
- Non-healing lesions
- Shifting teeth
- Change in fit of dentures
- Change in voice
- Trouble swallowing
- Neck mass
- Ear

GASTROINTESTINAL

- Abdominal or pelvic pain
- Nausea, vomiting
- Vomiting of blood
- Diarrhea
- Constipation
- Recent bowel changes
- Rectal bleeding or Black stool
- History of Diverticulitis or Colitis
- Yellow jaundice

MUSCULOSKELETAL

- Back pain
- Bone pain
- Swelling of an extremity

GENITOURINARY

- Urinary frequency
- Urinary pain
- Urinary burning

WOMEN ONLY

- Vaginal discharge
- Lump or mass in breast
- Breast pain

MEN ONLY

- Prostate problem
- Penile discharge
- Swollen testicle

Patient Signature _____

Nurse or Physician's Signature _____