

New Patient Medical History

Date: ____/____/____

Cell Phone: _____

Patient Name: _____

DOB: ____/____/____

Phone: _____

Sex: M F

Ref / PC Physician: _____ Pharmacy: _____ Add: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Allergies: _____

Please answer the following questions about your personal **PAST** medical history:

Cardio-vascular:

- | | | | | |
|---------------------------------------|---|---|---|---|
| <input type="checkbox"/> Heart attack | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Heart valve problems | <input type="checkbox"/> Irregular heart beat | <input type="checkbox"/> Coronary artery disease |
| <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Deep Vein Thrombosis | <input type="checkbox"/> Anemia | <input type="checkbox"/> Bleeding tendency | <input type="checkbox"/> Congestive heart failure |

Endocrine:

- | | | | | |
|--|--|---|--|---------------------------------------|
| <input type="checkbox"/> Insulin dependent | <input type="checkbox"/> Diabetes/diet | <input type="checkbox"/> <u>HYPER</u> thyroid | <input type="checkbox"/> <u>HYPQ</u> thyroid | <input type="checkbox"/> Gout disease |
|--|--|---|--|---------------------------------------|

GI:

- | | | | | |
|--------------------------------------|---|--|---|--|
| <input type="checkbox"/> Acid reflux | <input type="checkbox"/> Irritable bowels | <input type="checkbox"/> Peptic Ulcers | <input type="checkbox"/> Diverticulitis | <input type="checkbox"/> Constipation/diarrhea |
|--------------------------------------|---|--|---|--|

GU:

- | | | | | |
|--|---|---|---------------------------------------|---|
| <input type="checkbox"/> Kidney stones | <input type="checkbox"/> Bladder stones | <input type="checkbox"/> Frequent UTI's | <input type="checkbox"/> BPH | <input type="checkbox"/> Prostatitis |
| <input type="checkbox"/> Bloody urine | <input type="checkbox"/> Erectile dysfunction | <input type="checkbox"/> Elevated PSA | <input type="checkbox"/> Incontinence | <input type="checkbox"/> Overactive bladder |

HEENT:

- | | | | | |
|-----------------------------------|------------------------------------|-----------------------------------|----------------------------------|--|
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Cataracts | <input type="checkbox"/> Hayfever | <input type="checkbox"/> Vertigo | <input type="checkbox"/> Ear Infection |
|-----------------------------------|------------------------------------|-----------------------------------|----------------------------------|--|

Musculo-skeletal:

- | | | | |
|------------------------------------|--|---------------------------------------|--|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Low Back Pain | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Joint replaced: _____ |
|------------------------------------|--|---------------------------------------|--|

Neurologic:

- | | | | | |
|-----------------------------------|------------------------------------|---|--|---|
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Migraines | <input type="checkbox"/> Parkinson's | <input type="checkbox"/> Chronic headaches | <input type="checkbox"/> Multiple Sclerosis |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Polio | <input type="checkbox"/> Spinal cord injury | <input type="checkbox"/> Spina bifida | <input type="checkbox"/> Unsteady gait |

Pulmonary:

- | | | | | |
|------------------------------------|---------------------------------|-------------------------------------|-------------------------------|--------------------------------------|
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Asthma | <input type="checkbox"/> Bronchitis | <input type="checkbox"/> COPD | <input type="checkbox"/> Lung Cancer |
|------------------------------------|---------------------------------|-------------------------------------|-------------------------------|--------------------------------------|

Hematology/Oncology:

- | | | | | |
|--|---|--|--|--|
| <input type="checkbox"/> Prostate cancer | <input type="checkbox"/> Bladder cancer | <input type="checkbox"/> Kidney cancer | <input type="checkbox"/> Testicle cancer | <input type="checkbox"/> Colorectal cancer |
| <input type="checkbox"/> Uterine cancer | <input type="checkbox"/> Lymphoma | <input type="checkbox"/> Leukemia | <input type="checkbox"/> Ovarian cancer | <input type="checkbox"/> Other: _____ |

PAST SURGERIES:

- | | | | | | |
|--|---------------------------------------|--|---------------------------------|---|--|
| <input type="checkbox"/> Heart Surgery | <input type="checkbox"/> Gall Bladder | <input type="checkbox"/> Colon Resection | <input type="checkbox"/> Hernia | <input type="checkbox"/> Kidney Stones | <input type="checkbox"/> Nephrectomy |
| <input type="checkbox"/> Hysterectomy | <input type="checkbox"/> Thyroid | <input type="checkbox"/> Hip / Knee / Back | <input type="checkbox"/> Lung | <input type="checkbox"/> Basal Cell Carcinoma | <input type="checkbox"/> Squamous Cell Carcinoma |
| <input type="checkbox"/> Other: _____ | | | | | |

FAMILY MEDICAL HISTORY:

Father or Mother families or Sibling having any of the following?

- | | | |
|--------------------------|-----|-------------------------|
| Prostate Cancer | Y N | Father, Mother, Sibling |
| Kidney Cancer | Y N | Father, Mother, Sibling |
| Bladder Cancer | Y N | Father, Mother, Sibling |
| Colon Cancer | Y N | Father, Mother, Sibling |
| Bleeding Disorder | Y N | Father, Mother, Sibling |
| Polycystic Kidneys | Y N | Father, Mother, Sibling |
| Kidney Failure | Y N | Father, Mother, Sibling |
| Kidney or Bladder Stones | Y N | Father, Mother, Sibling |
| Urinary Tract Infections | Y N | Father, Mother, Sibling |
| Interstitial Cystitis | Y N | Father, Mother, Sibling |

MEDICATIONS (LIST NAME & DOSAGE):

SOCIAL HISTORY:

Please answer the following questions about your personal medical history (check those that apply):

Ever smoke? Y N If yes, packs/day _____ Years smoked: _____ Quit: Y N When? _____

Alcohol? Y N If yes, circle all that apply: Beer Wine Liquor Amount per week: _____

Do you take blood thinners? Y N If yes, circle which: Coumadin Plavix Aspirin

Do you take antibiotics before dental or other procedures? Y N

Do you have any artificial implants? Y N If yes, circle all that apply: Hip Knee(s) Heart Valve Pacemaker

Do you have HIV or AIDS? Y N

Do you have Hepatitis? Y N If yes, circle which type: A B C

SYMPTOMS:

Have you experienced now, or in the past, any of the following symptoms:

Constitutional:

Chronic fevers Y N
Poor appetite Y N
Chills or night sweats Y N
Bruises easily Y N

Eyes:

Blurred vision: Y N
Double vision: Y N
Eye Pain: Y N

Allergic/immunologic:

Animal Y N
Environmental Y N
Food Y N
Seasonal Y N

Neurologic:

Migraines Y N
Seizures Y N
Tremors Y N

Endocrine:

Excessive thirst Y N
Cold or heat intolerance Y N
Tired / sluggishness Y N
Decreased libido Y N

Gastrointestinal

Constipation Y N
Diarrhea Y N
Indigestion / heartburn Y N
Abdominal pain Y N

Cardiovascular:

Chest pain Y N
Vascular problems Y N
Palpitations Y N

Skin:

Skin Rashes Y N
Changing moles Y N
Pigment changes Y N

Musculoskeletal:

Joint pain Y N
Neck pain Y N
Back pain Y N

Ears/Nose/Throat/Mouth:

Hearing loss Y N
Sinus infections Y N
Difficulty swallowing Y N

Genitourinary:

Weak Stream Y N
Awaken to urinate Y N
Not emptying bladder Y N
Dribbling Y N
Urination burning Y N
Blood in Urine Y N

Respiratory:

Short of breath Y N
Wheezing Y N
Chronic cough Y N

Hematologic/Lymphatic:

Swollen glands Y N
Blood clots Y N
Bleeding problems Y N

Psychological:

Depression Y N
Anxiety Y N

I hereby authorize consent for treatment and release of any necessary information acquired in the course of examination and treatment by my physician for processing of my medical claim.

Signature of

Patient / Insured / Legal Guardian: _____

Date: _____