New Patient History Form

Name ____ Date ____________________________________

Primary Physician ______________________________ Birth Date _______________________________

Chief Concern / Complaint: ____

Current Medications: Please list all medications you are on, including vitamins, herbal supplements and contraception.

Medicine	Dosage / Times per day	Medicine	Dosage / Times per day

Allergies: Please list all medicines AND the "allergic reaction" as well as the approximate date or age.

Medicine	Reaction	Approximate date / age

Operations: Please list all surgeries and the approximate year it was done or age, such as, "Appendectomy, age 10"

____ ____

____ ____

____ ____

Past Medical History: Please list all major illnesses you have had and the date or age at diagnosis

____ ____

____ ____

____ ____

____ ____

____ ____

Other Physicians: Please list any other physicians involved in your care and their specialties

Prior PCP ______________________________________ ____

____ ____

____ ____

Social History:

Marital Status: (Circle one) M S D W How many years married (divorced or widowed) ___________

Children: *(please list name, age, and any major illnesses)*
____ ____
____ ____
____ ____

Occupation: ____ Educational Level: _______________________________

Years in Arizona: ________________ Born and Raised: City______________________ State:__________

Do you smoke? (Circle one) Yes / Never / Quit Packs per day: ________ How many years? _______ Quit date: _________

Other tobacco? (Circle any) Pipe / Cigars / Chew Number of times per day _________ Quit date: _________

Alcohol Use: On average, how many drinks per day? _________, per month? __________ Type: Beer / Wine / Liquor

Do you have a living will or advanced directive? Yes / No

Family Medical History: Only applies to genetically related relatives. List those with the condition and age at onset.

Cancer (type if known): ___________________________________ Arthritis ____

Heart Attack: ____ Asthma: ____

High Blood Pressure: ____________________________________ Depression: ______________________________________

Stroke: ____ Seizures: ____

Diabetes: ____ Other: ____

Review of Systems: Please circle those symptoms you have frequently or apply to you.

General: Weight gain / loss Number or pounds _______________ over the past _______________ months or _____________years.

Head: Headache
Dizziness
Injury

Eyes: Blurred vision
Pain
Spots or Lines

ENT: Hearing Loss
Ringing
Nasal congestion
Nosebleeds
Post nasal drip

Lungs: Short of breath
Wheezing
Cough
Pain with breathing

Cardiac: Chest pain
Palpitations
Rheumatic Fever
Short of breath with activity

GI: Heartburn
Trouble swallowing
Loss of appetite
Nausea
Bloody or black stool
Constipation
Diarrhea
Cramping
Hemorrhoids

Skin: Rash
Changing moles

Urinary: Frequent urination
Burning with urination
Blood
Dribbling
Leaking
Slow stream

Genital: History of herpes
Other STD's
Decrease sex drive
Decrease sexual performance

Women: Last menstrual period: ___________
Number of pregnancies: _______
Number of births: _________
Number of miscarriages/abortions: _____/____
History of abnormal Pap? Yes / No