New Patient Health History

Name: ______________________________ Date of Birth: ______________ Date: ______________

Primary Care Physician: ______________________________ Referring Physician: ______________________

Other physician(s): ____

Height: __________ Weight: ____________

Please answer the following the best you can. Some of these may be difficult to answer and the medical staff will assist you when you are brought to the exam room. Anything left blank will be assumed normal / not present.

Chief Complaint: ____

Location/site of the problem: ____

Quality of the problem (e.g. sharp or dull pain): ____

Severity of the problem (e.g. mild, moderate, severe): ____

Timing/duration of the problem (e.g. at night, one week): ____

Context (e.g. worsening, improving, recurrent): ____

Modifying factors (things that make it better or worse): ____

Associated signs or symptoms: ____

MEDICATIONS
Please list all prescription and nonprescription medicines

Medicine	Dose	How often
Example: Aspirin	81 mg	once a day

ALLERGIES / SENSITIVITIES
(Medicines, environmental and food

Allergy	Side Effects

SOCIAL HISTORY

❑ NO Tobacco Exposure ❑ Tobacco Exposure—Explain: ____________________ Age began ______________

Years Smoked _________ Average pack per day ______________ Age quit ___________

Alcohol use? ❑ Yes ❑ No If yes: number of drinks per week: ______________________________

Drugs use? ❑ Yes ❑ No If yes: please describe: ______________________________

PAST SURGICAL / MAJOR ILLNESS HISTORY (List as accurately as possible when, what and why.)

1. ______________________________ 2. ______________________________
3. ______________________________ 4. ______________________________

Flu Vaccine received? **YES or NO (cirlce one)** **When?** ______________ **Where?** ______________
Last Mammaogram received? **YES or NO (cirlce one)** **When?** ______________
Last Pneumococcal received? **YES or NO (cirlce one)** **When?** ______________ **Where?** ______________
Last Colonoscopy received? **YES or NO (cirlce one)** **When?** ______________

______________________________ ______________________________
Signature **Date**

FOR PEDIATRIC PATIENTS ONLY:

Was your child a product of a normal pregnancy & delivery? ❑ Yes ❑ No Please explain: ______________

Is your child in a daycare setting? ❑ Yes ❑No Please explain: ______________

Is your child's immunizations up to date? ❑ Yes ❑ No Please explain: ______________

FAMILY HISTORY – Do any of your family members have the following?

	YES	NO	RELATIONSHIP
Diabetes	❑	❑	______________
High blood pressure	❑	❑	______________
Heart disease	❑	❑	______________
Cancer	❑	❑	______________
Hearing loss	❑	❑	______________
Asthma	❑	❑	______________
Stroke	❑	❑	______________
Respiratory failure	❑	❑	______________
Bleeding disorders	❑	❑	______________
Anesthetic complications	❑	❑	______________ Explain: ______________
Other inherited diseases	❑	❑	______________ Explain: ______________

PATIENT MEDICAL HISTORY – pertaining only to the patient

	YES	NO	EXPLAIN
Fever/Chills	❑	❑	______________
Visual changes	❑	❑	______________
Hearing loss	❑	❑	______________
Drainage	❑	❑	______________
Ear pain	❑	❑	______________
Vertigo	❑	❑	______________
Ringing in ears	❑	❑	______________
Nasal blockage	❑	❑	______________
Sinus disease	❑	❑	______________
Mouth Pain	❑	❑	______________
Headache	❑	❑	______________
Throat Pain	❑	❑	______________
Hoarseness	❑	❑	______________
Difficult in swallowing	❑	❑	______________
Shortness of breath	❑	❑	______________
Chest pain	❑	❑	______________
Nausea	❑	❑	______________
Rash/Itching	❑	❑	______________
Change in smell/taste/vision	❑	❑	______________
Dizziness	❑	❑	______________
Light sensitivity	❑	❑	______________
Dry skin	❑	❑	______________
Hair Loss	❑	❑	______________
Enlarged glands	❑	❑	______________
Nasal/seasonal allergies	❑	❑	______________
Sleep disturbance	❑	❑	______________
Easy bleeding	❑	❑	______________
Easy bruising	❑	❑	______________

______________________________ ______________________________

Signature **Date**