PATIENT SHEET – INITIAL VISIT

NAME:_____ PRIMARY CARE/ REFEFFERING PHYSICIAN:_____

DRUG ALLERGIES:_____

LIST PREVIOUS SURGERIES	LIST REASONS FOR HOSPITALIZATIONS OTHER THAN SURGERY	LIST MEDICATIONS WITH DOSE AND HOW OFTEN TAKEN
1.	1.	1.
2.	2.	2.
3.	3.	3.
4.	4.	4.
5.	5.	5.
6.	6.	6.
7.	7.	7.
8.	8.	8.
9.	9.	9.

BRIEFLY DESCRIBE THE REASON FOR THE VISIT:

_____

_____

HAVE YOU EVER HAD?

- o HEART ATTACH
- o STROKE
- o DIABETES
- o HIGH BLOOD PRESSURE
- o BLEEDING ULCER
- o GASTRITIS
- o TUBERCULOSIS
- o POSITIVE TB SKIN TEST
- o ASTHMA
- o OTHER (EXPLAIN)
- o OTHER LUNG DISEASE
- o LIVER PROBLEMS
- o THYROID PROBLEMS
- o PSORIAIS
- o SEIZURES
- o CANCER
- o EMPHYSEMA
- o KIDNEY PROBLEMS (OTHER THAN INFECTION)

DO YOU HAVE PROBLEMS WITH?

- o DIFFICULTY SWALLING
- o ABNORMAL PAP SMEAR
- o RECURRENT SKIN RASH
- o RASH CAUSED BY SUNLIGHT
- o EXCESSIVE HAIR LOSS
- o RECURRENT MOUTH SORES
- o RECURRENT EYE INFLAMATION
- o LOW PLATELET COUNT
- o COLOR CHANGES OF HANDS WITH COLD
- o TINGLING OR NUMBNESS IN AN EXTREMITY
- o DIFFICULTY OR BURNING WITH URINATION
- o OTHER (EXPLAIN)
- o RAYNAUD'S DISEASE
- o PERICARDITIS
- o GOUT
- o ANEMIA
- o PLEURISY
- o TROUBLE SLEEPING
- o CROHN'S DISEASE
- o JOINT SWELLING
- o JOINT PAIN

NEW PATIENT MEDICAL HISTORY FORM

Patient Name: _____ Date of Birth:_____

Vital Sign: _____ Height:_____ Weight: _____

Review of Systems

Please indicate if you have experienced any of the following symptoms in the last 3 months?

○**None For All**

					None
1.	**CON**	○Weight Loss	○Loss Of Appetite	○Fatigue	○
2.	**EYE**	○Blurred Vision	○Double Vision	○Vision Loss	○
3.	**ENT**	○Hearing Loss	○Hoarseness	○Trouble Swallowing	○
4.	**CARDIO**	○Chest Pain	○Palpitations		○
5.	**RESP**	○Chronic Cough	○Pneumonia	○Shortness of Breath	○
6.	**GI**	○Heartburn, Ulcers	○Nausea, Vomiting	○Blood in Stool	○
7.	**GU**	○Painful Urination	○Blood in Urine	○Kidney Problems	○
8.	**SKIN**	○Frequent Rashes	○Skin Ulcers	○Lumps, Psoriasis	○
9.	**NEURO**	○Frequent Falls	○Loss of Coordination	○Numbness	○
		○Change in bowel	○Change in bladder	○Dizziness	○
10.	**PSYCH**	○Depression/Anxiety	○Drug/Alcohol Addiction	○Sleep Disorder	○
11.	**ENDO**	○Fever	○Heat or Cold	○Night Sweats	○

Comments:_____

Family History

Have any direct relatives had any of the following disorders?

○ **None for all**

○None	○Diabetes	○Heart Disease	○Hypertension
○Bleeding Problems	○Epilepsy	○Connective Tissue	○Muscular Dystrophy
○Stroke	○Osteoporosis	○Rheumatoid Arthritis	○Cancer

Comments:_____

Social History

1. Do you smoke tobacco? ○Current, every day smoker ○Current, some day smoker ○Former smoker ○Never smoked ○Heavy tobacco smoker ○Light tobacco smoker
2. Do you drink alcohol? ○Daily ○Occasionally ○Rarely ○Never
3. Marital History: ○Married ○Single ○Divorced ○Widowed ○Domestic Partnership
4. Are you currently working? ○Yes Occupation:_____ ○No ○Retired ○ Disabled

Comments:_____