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? **(CIRCLE IF APPLICABLE)**

HEART ATTACK
STROKE
DIABETES
HIGH BLOOD PRESSURE
BLEEDING ULCER
GASTRITIS
TUBERCULOSIS
POSITIVE TB SKIN TEST
ASTHMA
OTHER (EXPLAIN)

OTHER LUNG DISEASE
LIVER PROBLEMS
THYROID PROBLEMS
PSORIAIS
SEIZURES
CANCER
EMPHYSEMA
KIDNEY PROBLEMS (OTHER THAN INFECTION)

DO YOU HAVE PROBLEMS WITH? **(CIRCLE IF APPLICABE)**

DIFFICULTY SWALLOWING
ABNORMAL PAP SMEAR
RECURRENT SKIN RASH
RASH CAUSED BY SUNLIGHT
EXCESSIVE HAIR LOSS
RECURRENT MOUTH SORES
RECURRENT EYE INFLAMATION
LOW PLATELET COUNT
COLOR CHANGES OF HANDS WITH COLD
TINGLING OR NUMBNESS IN AN EXTREMITY
DIFFICULTY OR BURNING WITH URINATION

RAYNAUD'S DISEASE
PERICARDITIS
GOUT
ANEMIA
PLEURISY
TROUBLE SLEEPING
CROHN'S DISEASE
JOINT SWELLING
JOINT PAIN
OTHER (EXPLAIN)

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:____