

New Patient Information

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date Of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referred By: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Care Provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medication List:

|  |  |  |
| --- | --- | --- |
| Medication | Dose | Frequency |
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Allergies/Sensitivities/Reactions:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

History Of Tobacco Use: Yes \_\_\_\_\_\_\_ No\_\_\_\_\_\_\_\_ If yes, substance/frequency:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Alcohol Use: Yes \_\_\_\_\_ No \_\_\_\_\_\_ If yes, substance/frequency:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Recreational Drug Uses: Yes\_\_\_\_\_\_\_ No\_\_\_\_\_\_\_\_ If yes, substance/frequency:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Surgical History:

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| --- | --- | --- |
| Date (Approximate) | Type of Surgery | Hospital |
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Medical History (Please check all that apply to you now or in the past.):

Genitourinary:

Yes No

  Frequent Urination

  Nighttime Urinary Frequency

  Burning with Urination

  Blood in Urine

  Lack of Bladder Control

  Weak Urine Stream

  Urinary Tract Infections

  Kidney Stones

  Kidney Failure

  Enlarged Prostate

  Prostate Cancer

  Bladder Cancer

  Kidney Cancer

  Testicular Cancer

  Erectile Dysfunction

Gastrointestinal:

Yes No

  Stomach Ulcers

  Gastric Reflux/Heartburn

  Hepatitis (Specify A,B,C)

  Liver Disease

  Blood in Stool

  Black(Tarry) Stool

  Constipation

  Diarrhea

  Change in Bowel Movement

  Abdominal Pain

  Nausea/Vomiting

  Crohns Disease

  Irritable Bowel Syndrome

  Ulcerative Colitis

  Colon Cancer

Cardiovascular:

Yes No

 Rheumatic Fever

 Heart Murmur

 Palpitations

 Irregular Heartbeat

 Chest Pain

 Heart Attack

 High Blood Pressure

 Heart Failure

 High Cholesterol

 Stroke/Mini Stroke(TIA)

 Blood Clots (DVT)

 Pulmonary Emboli

 Varicose Veins

 Pain in legs with walking

 Bruising/Bleeding Tendency

 Aneurysms

Other:

Yes No

  Sexually Transmitted Disease

  Depression

  Anxiety

  Chronic Fatigue

  Fibromyalgia

  Arthritis

  Degenerative Arthritis

  Rheumatoid Arthritis

  Glaucoma

  Thyroid Disease

   Hyperthyroid

   Hypothyroid

  Goiter

  Thyroid Cancer

  HIV/AIDS

  Diabetes

  Steroid Use

  Skin Cancer

  Headaches

  Weight Loss

  Anemia

Please list any other Medical Conditions: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Respiratory:

Yes No

  Asthma

  Wheezing

  Emphysema

  COPD

  Chronic Cough

  Tuberculosis

  Sleep Apnea

  Oxygen Use

  Lung Cancer

Health Maintenance

Please answer the following:

When was your last influenza vaccine(Flu Shot)?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When was your last Tetanus Shot?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If you have had a Pneumovax, please provide the date of your last one:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If you have had a Zostavax (Shingles), please provide the date of your last one: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If you have had a colonoscopy, please provide the date of your last one:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_