



Date _____

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New Patient Medical History Form

Print and complete this form prior to your appointment

Date _____

Name _____ **DOB** (mm/dd/yy) _____ **Age** _____

1. Reason for consultation: (what is the main reason for your visit today)

2. Past Medical History: Please select any medical condition from which you have been diagnosed or treated

- | | | |
|--|--|--|
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Condition | <input type="checkbox"/> Liver problems |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Stomach Ulcers/reflux/ Celiac disease | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Cholesterol/Triglycerides | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Thyroid problems | <input type="checkbox"/> Kidney problems | <input type="checkbox"/> Osteoporosis/Osteopenia |
| <input type="checkbox"/> Respiratory problems | <input type="checkbox"/> Rheumatologic disorders (lupus, rheumatoid arthritis) | |
| <input type="checkbox"/> Other, please specify _____ | | |

3. Allergies: Please list any allergic reactions or adverse side effects to any drugs, food or environment.
Type of Reaction

1. _____	_____
2. _____	_____
3. _____	_____

4. Medications: Please list the current prescription and non-prescription medications you are currently taking, specify strength and frequency.

Prescribed: Name	Strength	Times/day	Over the Counter
1. _____	_____	_____	a. _____
2. _____	_____	_____	b. _____
3. _____	_____	_____	c. _____
4. _____	_____	_____	d. _____
5. _____	_____	_____	e. _____

5. Surgical history/hospitalizations: Please select any surgeries or hospitalizations including fractures and traumas you have had in the past.

- | | | | |
|---|---|--------------------------------------|--|
| <input type="checkbox"/> Tonsils | <input type="checkbox"/> Appendix | <input type="checkbox"/> Gallbladder | <input type="checkbox"/> Heart surgery (CABG/stents) |
| <input type="checkbox"/> Thyroid • Year _____ | partial/complete | | <input type="checkbox"/> Parathyroid • Year _____ |
| <input type="checkbox"/> Head Trauma • Year _____ | <input type="checkbox"/> Hysterectomy: partial/complete | | |
| <input type="checkbox"/> Kidney stones • Year _____ | <input type="checkbox"/> Bone Fracture(s) • Site _____ | | |
| <input type="checkbox"/> Other _____ | | | |

6. Family History: Please identify all illnesses or medical conditions that are/were present in you blood relatives.

Mother _____	maternal side _____
Father _____	paternal side _____
Brother _____	son/daughter _____
Sister _____	

7. Personal/Social History: Tell us about yourself

Home situation

Single Married/Partner Divorced/Separated Widowed

Occupation/Employment _____

Full time Part-time Unemployed Retired Disabled

Habits

Do you smoke? Yes No Former
If yes, how many packs/day? _____ For how long? _____

Do you drink alcohol? Yes No Former
If yes, how many drinks per day/week/month? _____
If you quit, when? _____

Do you use illicit drugs? Yes No Former

How often do you exercise?
 Everyday 1-2 times/wk 2-3 times /wk 3-4 times/wk Seldom/Never

What activity? _____
How long do you exercise for? 15-20 min 20-40 min 40-60 min 60 – 90 min

Review of Symptoms

Have you experienced any of the following problems recently? Check if YES

General

- Weight loss _____ lbs _____ (time period)
- Weight gain _____ lbs _____ (time period)
- Poor sleep Sleep too much
- Fatigue/loss of energy
- Fever/night sweats/chills
- Feeling forgetful
- Intolerance to heat or cold

Head, Eyes, Ears, Throat

- Headaches or migraines
- Dizziness/lightheadedness
- Blurry or double vision
- Dry eyes
- History of glaucoma, cataracts
- Loss of hearing, ringing in ears
- Sinus problems

Neck

- Neck swelling/enlargement
- Neck pain
- Lumps in the neck
- Hoarseness, voice changes
- Difficulty swallowing

Cardiovascular/Respiratory

- Chest pain or discomfort
- Palpitation/rapid heart beat
- Shortness of breath upon activity
- History of heart attack
- Irregular heart beat
- History of a murmur
- Chronic or persistent cough
- Wheezing
- Coughing up blood

Gastrointestinal

- Abdominal pain or cramps
- Constipation
- Loose stools/diarrhea
- Blood in the stools
- Nausea/vomiting
- History of heartburn (reflux)/ulcer
- History of liver disease or abnormal tests

Urinary

- frequent urination day / night
- History kidney failure
- History of kidney stones
- Blood in the urine
- Excessive thirst
- Urinary incontinence

Skin

- Rashes
- Change in tone or color of skin
- Excess of hair growth
- Hair loss
- Itchiness
- Bruising easily
- Purple stretch marks

Muscle/Joint/Bone

- Muscle aches or pain
- Muscle weakness
- Enlargement of hat or finger size
- History of osteoporosis/ fall
- History of chronic fatigue

Neurologic/Psychiatric

- Loss of consciousness/blackout
- History of stroke
- Numbness/tingling in hands/feet
- Leg cramps when walking/at night
- History of seizures
- Symptoms of anxiety/depression

Breast

- Nipple Discharge
- Masses
- Tenderness

Hematologic/Lymphatic

- Swollen lymph node
- Bleeding/Immune disorder
- Blood transfusion • Year

Female patients only

- Age of your first menstrual cycle _____
- Last date of your cycle _____ Regular cycles Irregular cycles
- Onset of Menopause _____
- Hysterectomy Complete (uterus + ovaries) Partial (uterus)
- Have you taken estrogen Yes No Duration on treatment _____
- Are you currently on contraception Yes No Specify name and for how long
- Vaginal discharge
- Breast discharge or lumps
- Date of last mammogram _____
- Date of last pap smear _____
- Number of pregnancies _____ Abortions or miscarriages _____
- Number of Full live births _____

Male patients only

Have you been diagnosed or treated for erection difficulties, prostate problems, prostate surgery, and vasectomy? Y N

Do you have decrease in libido (sex drive)? Y N

Do you have lack of energy? Y N

Do you have a decrease in strength or endurance? Y N

Have you lost height? Y N

Do you feel sad and grumpy? Y N

Are your erections weaker? Y N

Are you falling asleep after dinner? Y N

Has there been a recent deterioration in your work performance? Y N

Have you lost muscle mass? Y N

We appreciate your time in filling out this questionnaire.