NEW PATIENT HEALTH HISTORY
(CONFIDENTIAL)
-A-

PATIENT NAME:_____APPOINTMENT DATE_____
AGE_____DATE OF BIRTH_____DATE OF MOST RECENT PHYSICAL_____
REASON FOR THIS VISIT:

PLEASE LIST THE NAME, ADDRESS, AND PHONE NUMBER OF OTHER PHYSICIANS WHO HAVE TREATED YOU FOR ANY MEDICAL PROBLEM IN THE RECENT PAST.

INTERNIST (FAMILY PHYSICIAN) _____

OB-GYN_____

ORTHOPEDIST_____

SURGEON_____

OTHER_____

PLEASE NOTE ANY PAST TREATMENT FOR ARTHRITIS (CHECK ALL PREVIOUSLY USED)

EFFECT (HELPED, NO HELP). IF IT CAUSED A SIDE EFFECT, PLEASE SPECIFY WHAT KIND.

[] Allopurinol _____
[] Ansaid / flurbiprofen _____
[] Aspirin / Disalcid / Trilisate _____
[] Azulfidine / sulfasalazine _____
[] Benemid / Probenecid _____
[] Bextra / Valdecoxib _____
[] Celebrex / celecoxib _____
[] Clinoril / sulindac _____
[] Cupramine / Depen / Penicillamine _____
[] Cytoxan / cyclophosphamide _____
[] Daypro / oxaprozen _____
[] Dolobid / diflunisal _____
[] Feldene / piroxicam _____
[] Imuran / asathioprine _____
[] Indocin / Indochron / indomethacin _____
[] Lekeran / chlorambucil _____
[] Lodine / etodolac _____
[] Meclomen _____
[] Mobic / Meloxicam _____
[] Motrin / Advil / Nuprin / ibuprofen _____
[] Nalfron / fenoprofen _____
[] Naprosyn / Anaprox / naproxen _____
[] Orudis /Oruvail / ketoprofen _____
[] Relafen / nebumatone _____
[] Tolectin / sodium tolmetin _____
[] Toradol / ketorolac _____
[] Ultram / Ultracet _____
[] Vioxx / rofecoxib _____
[] Voltaren / Cataflam _____
[] "Cortisone shots" in joints _____
[] "Cortisone shots" in muscles _____
[] Gold shots / Gold pills _____
[] Methotrexate / Rheumatrex / Trexall _____
[] Plaquenil _____
[] Prednisone _____
[] Other:_____ _____
_____ _____

PATIENT NAME: _____ DATE OF BIRTH _____

ALLERGIES OR REACTION TO MEDICATIONS

Medication	**Reaction**

Please list all current medications. Please bring all of your medications to your first office visit.
(Use the back of this page if you need more space)

Name of drug	Strength	How do you take this drug ?	Date this drug first prescribed

History: Please circle "Y" (yes) or "N" (no)

Skin — Date Began

Y N Bruises easily _____
Y N Changes in Moles _____
Y N Sores that won't heal _____

HEAD, EYES, EARS, NOSE, THROAT

Y N Migraine headaches _____
Y N Tension Headaches _____
Y N Cataracts _____
Y N Glaucoma _____
Y N Blurred vision _____
Y N Double vision _____
Y N Vision – flashes _____
Y N Vision – halos _____
Y N Ear ache _____
Y N Ear discharge _____
Y N Loss of hearing _____
Y N Ringing in ears _____
Y N Hayfever _____
Y N Sinus problems _____
Y N Nose bleeds _____
Y N Difficulty swallowing _____
Y N Hoarseness _____
Y N Dizziness _____

PATIENT NAME: _____ DATE OF BIRTH _____

SWOLLEN GLANDS:

Y N … in neck _____

Y N … in groin _____

BREASTS

Y N Lumps _____

Y N Nipple discharge _____

METABOLIC

Y N Diabetes _____

Y N Thyroid disease _____

Other: _____

HEMATOLOGIC

Y N Anemia _____

Y N Blood clots _____

Y N Bleeding disorder _____

Other (Specify) _____

CARDIOVASCULAR / PULMONARY

Y N Chest pain _____

Y N High blood pressure _____

Y N Irregular heart beat _____

Y N Low blood pressure _____

Y N Poor circulation _____

Y N Rapid heart beat _____

Y N Swelling of ankles/feet _____

Y N Varicose veins _____

Y N Difficulty breathing _____

Y N Chronic cough _____

Y N Pneumonia _____

Y N Asthma _____

Y N Bronchitis _____

Y N Emphysema _____

Y N Pacemaker _____

Y N Heart Attack _____

Y N Angina _____

Y N Enlarged Heart _____

Y N Heart murmur _____

GASTROINTESTINAL

Y N Poor appetite _____

Y N Bloating _____

Y N Bowel changes _____

Y N Constipation _____

Y N Diarrhea _____

Y N Irritable Bowel Syndrome _____

Y N Gas _____

Y N Hemorrhoids _____

PATIENT NAME_____DATE OF BIRTH_____

Y N Indigestion_____
Y N Nausea_____
Y N Rectal bleeding_____
Y N Stomach pain_____
Y N Vomiting_____
Y N Ulcer_____
Y N Black stools_____
Y N Liver disease_____
Y N Skin turns yellow/jaundice_____
Y N Gallstones_____
Y N Weight loss/gain_____
Other (Specify) _____

GENITOURINARY

Y N Blood in urine_____
Y N Frequent urination_____
Y N Lack of bladder control_____
Y N Painful urination_____
Y N Kidney stones_____
Y N Kidney infection_____

(MEN ONLY)

Y N Erection difficulties_____
Y N Lump in testicles_____
Y N Penis discharge_____
Y N Sore on penis_____

(WOMEN ONLY)

Y N Abnormal PAP smear_____
Y N Bleeding between periods_____
Y N Extreme menstrual pain_____
Y N Hot flashes_____
Y N Painful intercourse_____
Y N Vaginal discharge_____
Y N Vaginal infections_____

Date of last menstrual period:_____Date of last PAP smear_____
Date of last mammogram_____Date of last DEXA (bone) scan_____
Are you pregnant? Y N ; # of pregnancies_____; # of vaginal deliveries_____
# of Cesareans_____; # of abortions / miscarriages_____; # of children_____
Y N Hysterectomy; Date_____ Vaginal or Abdominal (circle one)
Y N Do your ovaries remain? Y N Was hysterectomy done for cancer? Y N
Y N Fever: Describe time of day and temperature_____

CANCER: Please list any diagnosed cancers and treatment:

_____
_____

PATIENT NAME_____ DATE OF BIRTH_____

NEURO-PSYCHIATRIC

Y N Paralysis_____
Y N Seizures_____
Y N Neuropathy_____
Y N Anxiety_____
Y N Depression_____
Y N Other_____

SERIOUS INFECTIONS (please provide year diagnosed)

Y N AIDS_____ Y N Gonorrhea_____
Y N Syphilis_____ Y N Herpes_____
Y N Hepatitis A_____ Y N Hepatitis B_____
Y N Hepatitis C_____ Y N Tuberculosis_____
Y N HIV positive_____ Y N Lyme disease_____
Y N Measles_____ Y N Chicken pox_____
Y N Polio_____ Y N Pneumonia_____
Y N Mononucleosis_____ Y N Rheumatic fever_____
OTHER: _____

SERIOUS INJURY OR BROKEN BONES

YEAR INJURY / BONE BROKEN

_____
_____
_____
_____

OPERATIONS

YEAR OPERATION PERFORMED

_____
_____
_____
_____

PERSONAL AND SOCIAL HISTORY:

Are you single, married, widowed, divorced, or separated? (circle one)
If married, how many times? _____
If employed, what is your occupation? _____
Spouse's occupation? _____
Do you live in a house, condo, apartment, trailer or other_____? (cicle one)
With whom do you live? _____
Describe weekly alcohol consumption_____
Cigarette smoking_____packs per day for _____years.
Drug abuse: Y N If yes; which drug(s) _____
Regular exercise Y N If yes, describe_____

_____

List any other pertinent information not previously indicated: _____

_____

_____

_____

PATIENT NAME: _____ DATE OF BIRTH_____

FAMILY HISTORY: (Fill in health information about your family)

Relation	Age – Age at Death -	Medical Illness / Cause of Death
Father	_____/_____	_____
Mother	_____/_____	_____
Brothers	_____/_____	_____
	_____/_____	_____
	_____/_____	_____
	_____/_____	_____
	_____/_____	_____
	_____/_____	_____
Sisters	_____/_____	_____
	_____/_____	_____
	_____/_____	_____
	_____/_____	_____
	_____/_____	_____
	_____/_____	_____
Children	_____/_____	_____
	_____/_____	_____
	_____/_____	_____
	_____/_____	_____
	_____/_____	_____
	_____/_____	_____

Physician Signature_____ Date_____