New Patient - Self Reporting Form (pg 1/3)

Name: _____ Age: _____ Date: _____
DOB: _____ Family Doctor _____ Pharmacy_____

Medications (include supplements, inhalers, birth control and over the counter medications):

Name *Frequency* *Dose*

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Allergies (especially medications, specify reaction): Latex Allergy: Yes / No

_____
_____

Past Surgical History (please include year):

Appendectomy ____, Cholecystectomy ____, Tonsillectomy____, Hernia Repair____,
Hysterectomy ____ (ovaries)____, C-Section____, Tubal Ligation____.
Other: _____
_____

Trauma, Hospitalizations or Serious Illnesses:

_____
_____

Health Hazards (quantity, frequency and duration of use):

Alcohol: _____
Tobacco: _____
Caffeine: _____
Drugs: _____

Occupational Concerns (work exposure):

Stress: _____
Heavy Lifting: _____
Occupation: _____

New Patient - Self Reporting Form (pg 2/3)

Name: _____ Age: _____ Date: _____
DOB: _____

Personal Medical History			Family Medical History		
Yes	**No**	**Medical Problem**	**Yes**	**No**	**Relationship**
		Diabetes Mellitus			
		Hypertension (High Blood Pressure)			
		Hyperlipidemia (High Cholesterol)			
		Heart Disease (Angina, Heart Attack)			
		Congestive Heart Failure			
		Asthma			
		Lung Disease (COPD, Emphysema)			
		Stroke or TIA			
		Seizure Disorder			
		Mental Illness (Depression, Anxiety)			
		Abdominal Problems (Peptic Ulcer, Reflux, Colitis, Pancreatitis, Hepatitis)			
		Kidney Stones, Renal Failure			
		Anemia, Sickle Cell, Clotting disorder			
		Arthritis			
		Thyroid disease			
		Eye Disease (Cataracts, Glaucoma)			
		Skin Disorders (Eczema, Psoriasis)			
		Environmental or Food Allergies			
		Cancer or Leukemia			
		Alcoholism			
		Sexually Transmitted Disease, AIDS			
		Physical or Mental Disabilities			

Notes:

_____
_____
_____
_____
_____
_____

Information Reviewed by: _____ **Date:** _____

New Patient - Self Reporting Form (pg 3/3)

Name: _____ Age: _____ Date: _____
DOB: _____

Review of Symptoms

Yes	No	Symptoms
YES	NO	**GENERAL**
		Change in weight/gaining or losing
		Change in appetite (increase or decrease)
		Tiredness or fatigue
		Fever or chills
		Night sweating/increase in sweating
		Change in sleep pattern
		Excessive or prolonged bleeding
		Feel too hot/cold compared to others
		Excessive thirst
		Change in skin color—paleness
		Change in hair pattern
		Swollen glands
		Easy bruising
		Excessive or prolonged bleeding
YES	NO	**BRAIN—NERVES**
		Headache
		Unsteady when walking or sitting
		Numbness or tingling—Tremor—room spinning
		Changes in memory, personality, mood or anxiety
YES	NO	**EYES—EARS—NOSE--THROAT**
		Red eye(s)
		Vision problem (blurred or double vision)
		Hearing problems
		Ear pain or discharge
		Ringing sound in ears
		Runny nose or nose bleed
		Sore throat—Hoarseness
		Ulcer or sore in the mouth
		Lumps in neck or enlarged thyroid (goiter)
		Significant snoring—sleep apnea
YES	NO	**FOR MEN ONLY**
		Penile discharge—ulcers—lesions
		Testicular mass or pain
		Impotence or sexual dysfunction

Yes	No	Symptoms
YES	NO	**HEART AND LUNG**
		Chest pain
		Shortness of breath: with exercise, lying down or middle of night
		Heart fluttering (palpitations)
		Fainting or dizziness
		Edema (ankle or leg swelling)
		Leg cramps with walking or exercise
		Wheeze—cough—sputum—coughing blood
YES	NO	**STOMACH—INTESTINES**
		Difficulty swallowing—Heartburn
		Nausea or vomiting—vomiting blood
		Diarrhea or constipation
		Abdominal pain
		Blood, mucus or tarry stools
		Hemorrhoids
		Jaundice (yellowish skin or eyes)
YES	NO	**KIDNEY—BLADDER**
		Pain on urination—blood in urine
		Wake up to urinate
		Urinate very frequently
		Incontinence
YES	NO	**MUSCLES--JOINTS**
		Pain, stiffness, swelling, redness in joint/muscle
		Decrease in muscle strength (weakness)
		Backache
YES	NO	**FOR WOMEN ONLY**
		Pregnancies: # of
		Abortions or miscarriages
		Breast lump discharge from nipples
		Discharge from nipples
		Date of last Pap:
		Date of last Mammogram:

Information obtained from (relation to patient):_____

Notes: _____

_____

_____

Information Reviewed by:_____ **Date::** _____