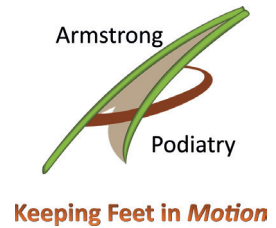


# New Patient Form



Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
 Primary Care Physician: \_\_\_\_\_ Last Visit w/PCP: \_\_\_\_\_  
 Endocrinologist: \_\_\_\_\_ Last Visit w/Endo: \_\_\_\_\_ Referred By: \_\_\_\_\_

Please describe your problem (include date of injury if applicable): \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

## PAST MEDICAL HISTORY

Check all that apply:

<input type="checkbox"/>	Frequent Headache/Migraine	<input type="checkbox"/>	Anemia / Blood Disorders
<input type="checkbox"/>	Rheumatic Fever	<input type="checkbox"/>	Pneumonia
<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	Drug/Alcohol Abuse
<input type="checkbox"/>	Dialysis MWF or T TH Sa	<input type="checkbox"/>	Epilepsy / Seizures
<input type="checkbox"/>	Diabetes Average Blood Sugar: _____	<input type="checkbox"/>	Prolonged Bleeding Time
<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	Stomach Disorder
<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	Thyroid / Parathyroid Disease
<input type="checkbox"/>	Heart Trouble	<input type="checkbox"/>	High Blood Pressure
<input type="checkbox"/>	Stroke	<input type="checkbox"/>	Arthritis
<input type="checkbox"/>	Chest Pain on Mild Exertion	<input type="checkbox"/>	Psychiatric Treatment
<input type="checkbox"/>	Gout	<input type="checkbox"/>	Emotional Problems / Tension
<input type="checkbox"/>	BLOOD CLOTS	<input type="checkbox"/>	Asthma / Hay Fever / Shortness of Breath
<input type="checkbox"/>	Tumor / Abnormal Growth / Cancer	<input type="checkbox"/>	Prostate Disorder
<input type="checkbox"/>	Ear / Nose / Throat Disorder	<input type="checkbox"/>	Sexually Transmitted Disease

Has any FAMILY MEMBER had any of the following problems (Please indicate relationship):

Cancer: \_\_\_\_\_ Diabetes: \_\_\_\_\_ Heart Trouble: \_\_\_\_\_  
 High Blood Pressure: \_\_\_\_\_ Kidney Disease: \_\_\_\_\_ Stroke: \_\_\_\_\_  
 Mental or Emotional Disease: \_\_\_\_\_ Tuberculosis: \_\_\_\_\_  
 Arthritis: \_\_\_\_\_ Emphysema: \_\_\_\_\_ BLOOD CLOTS: \_\_\_\_\_

## PATIENT INFORMATION

Do you currently smoke? \_\_\_ No \_\_\_ Yes If yes, how many packs /day? \_\_\_\_\_ How many years? \_\_\_\_\_  
 Smoke previously? \_\_\_ No \_\_\_ Yes If yes, how many packs/day? \_\_\_\_\_ How many years? \_\_\_ Year Quit: \_\_\_\_\_  
 Number of caffeine drinks per day: \_\_\_\_\_ Amount of alcohol consumed per week? \_\_\_\_\_

Please complete the following:

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Shoe Size: \_\_\_\_\_ Occupation: \_\_\_\_\_  
 Marital Status: \_\_\_ Single \_\_\_ Married \_\_\_ Divorced \_\_\_ Widowed \_\_\_ Other: \_\_\_\_\_  
 Exercise Type/Duration/ Frequency (Example: Walk 10 minutes 3X per week): \_\_\_\_\_  
 \_\_\_\_\_

ALLERGIES

Please check all allergies:

\_\_\_ Medications: \_\_\_\_\_

\_\_\_ Foods: \_\_\_\_\_

\_\_\_ Tapes \_\_\_ Novocain \_\_\_ Anesthetics \_\_\_ Silver/Nickel/Costume Jewelry \_\_\_ Other: \_\_\_\_\_

What types of reactions have you experienced? \_\_\_\_\_

\_\_\_\_\_

MEDICATIONS

Please list all prescription and over-the-counter medications and the dosages: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

SURGICAL HISTORY

Surgical Procedures/Serious Injuries/Illnesses	Year	Physician	Hospital

HEALTH REVIEW

Please circle any symptoms you have had in the past 3 months:	
General	Fever Chills Fatigue Weight Loss Weight Gain
Head	Headaches Visual Problems Hearing Problems Light Sensitivity
Cardiovascular	Chest Pain Palpitations Dizziness Swelling of Legs Other
Hematology	Anemia Abnormal Bleeding/Bruising Blood Clots Other Blood Disorder
Respiratory	Persistent Cough Wheezing Shortness of Breath
Gastrointestinal	Difficulty Swallowing Indigestion/Heartburn Abdominal Pain Change in Bowel Habits
Urinary	Painful Urination Frequent Night-time Urination Bladder Leakage Other
Musculoskeletal	Joint Pain/Swelling/Stiffness Back Pain Arthritis Muscle Weakness
Skin	Skin Rash Suspicious Lesions Itching
Neurological	Numbness of hands/feet Seizures Tremors Paralysis
Psychiatric	Depression Anxiety Problems Sleeping Memory Loss
Endocrine	Heat/Cold Intolerance Hot Flashes Change in hair/skin texture Other

The information provided here is true to the best of my knowledge. I authorize release of any previous medical records by fax, mail, or phone by either physician or hospital. Also, I hereby authorize the doctor or her assistants to initiate the diagnosis and treatment of my condition with x-ray, examination, or photographs of infections as necessary.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

I have personally reviewed the above information:
Physician Signature: _____ Date: _____