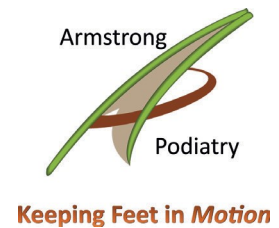


New Patient Form



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:

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