Patient Name_____ Date of Birth_____MRN _____

NEW PATIENT REVIEW OF SYMPTOMS

*Please clearly mark all symptoms you are **CURRENTLY** experiencing*

Constitutional
☐ Fever
☐ Chills
☐ Unexpected weight loss
☐ Fatigue
☐ Excessive Sweating

Skin
☐ Rash
☐ Itching

Hearing Ears Nose Throat
☐ Hearing loss
☐ Ringing in ears
☐ Ear pain
☐ Ear discharge
☐ Nosebleeds
☐ Congestion
☐ Sinus pain
☐ Noisy breathing
☐ Sore throat

Eyes
☐ Blurred vision
☐ Double vision
☐ Light sensitivity
☐ Eye pain
☐ Eye discharge
☐ Eye redness

Cardiovascular
☐ Chest Pain
☐ Palpitations
☐ Trouble breathing while lying flat
☐ Leg swelling
☐ Trouble breathing at night

Respiratory
☐ Cough
☐ Coughing up blood
☐ Shortness of breath
☐ Wheezing

Gastrointestinal
☐ Heartburn
☐ Nausea
☐ Vomiting
☐ Abdominal pain
☐ Diarrhea
☐ Constipation
☐ Blood in stool
☐ Dark or tarry stools

Genitourinary
☐ Painful urination
☐ Urinary urgency
☐ Urinary frequency
☐ Blood in urine
☐ Painful sex
☐ History of STD's

Males
☐ Penile discharge
☐ Trouble getting erections

Females
☐ Irregular periods
☐ Heavy periods
☐ Vaginal discharge

Musculoskeletal
☐ Muscle pain
☐ Neck pain
☐ Back pain
☐ Joint pain
☐ Falls

Endocrine/Hematological
☐ Easy bruising or bleeding
☐ Environmental allergies
☐ Excessive thirst

Neurological
☐ Dizziness
☐ Headaches
☐ Tingling
☐ Tremor
☐ Sensory change
☐ Speech change
☐ Localized weakness
☐ Generalized weakness
☐ Seizures
☐ Loss of consciousness

Psychological
☐ Depression
☐ Suicidal ideas
☐ Substance abuse
☐ Hallucinations
☐ Nervousness/Anxiety
☐ Trouble sleeping
☐ Memory loss

PLEASE COMPLETE OTHE SIDE OF FORM ➡

Patient Name_____ Date of Birth_____MRN _____

NEW PATIENT HEALTH HISTORY

PREFERRED NAME _____ PREFERRED GENDER _____

Please list concerns you would like to speak to your provider about - _____
_____
_____

Current medical conditions - _____
_____
_____

Current medications- _____
_____
_____

Allergies- _____

Past medical conditions- (*Things that are no longer an issue*): _____
_____

Surgeries- (*Type and Dates*): _____

FAMILY HEALTH HISTORY

Father – ☐Heart Disease ☐ High Blood Pressure ☐ High Cholesterol ☐Stroke ☐ Diabetes ☐Mental Illness ☐Colon Cancer ☐ Breast Cancer ☐ Prostate Cancer

Mother - ☐Heart Disease ☐ High Blood Pressure ☐ High Cholesterol ☐Stroke ☐ Diabetes ☐Mental Illness ☐Colon Cancer ☐ Breast Cancer ☐ Ovarian Cancer ☐ Uterine Cancer ☐ Cervical Cancer

Grandparents - ☐Heart Disease ☐ High Blood Pressure ☐ High Cholesterol ☐Stroke ☐ Diabetes ☐Mental Illness ☐Colon Cancer ☐ Breast Cancer ☐ Prostate Cancer ☐ Ovarian Cancer ☐ Uterine Cancer ☐ Cervical Cancer

Siblings - ☐Heart Disease ☐ High Blood Pressure ☐ High Cholesterol ☐Stroke ☐ Diabetes ☐Mental Illness ☐Colon Cancer ☐ Breast Cancer ☐ Prostate Cancer ☐ Ovarian Cancer ☐ Uterine Cancer ☐ Cervical Cancer

Pregnancies

How many times have you been pregnant? How many babies have you delivered? Vaginal or C-section?
_____
Any complications? _____

SOCIAL HISTORY

Education _____ Current Job _____
Marital status _____ Number of children _____
Who lives at home with you? _____
Do you smoke? ☐ Yes ☐ No Do you drink? ☐ Yes ☐ No If yes, how often: _____
Preferred sexual partners ☐ Male ☐ Female ☐ Both ☐ Decline to answer

Health Screening Dates - *(If known)*

Last tetanus _____ Flu vaccine_____ Hep B_____ Shingles_____ Pneumonia _____
PAP _____ Mammogram_____ Colonoscopy _____ DEXA Scan _____

PLEASE COMPLETE OTHER SIDE OF FORM