New Patient Form

Patient Sticker

General Information, Reason for your visit _____

Allergies _____

Pain Assessment	**Yes**	**No**
Are you in any pain		

Review of Systems (Subjective)	**Yes**	**No**
Have you experienced these symptoms in the last 6 months		
General Symptoms		
Fatigue		
Fever / Chills		
ENT		
Cold Sores		
Ear Problems		
Nosebleeds		
Respiratory		
Cough		
Shortness of Breath		
Wheezing		
Cardiovascular		
Chest Pain		
Leg Pain with walking		
Palpitations		
Gastrointestinal		
Nausea / Vomiting		
Trouble Swallowing		
Bloating		
Abdominal distention		
Fecal incontinence		
Bowel urgency		
Feeling full easily		
Excess gas		
Genitourinary		
Blood in Urine		
Trouble Urinating		
Skin		
Acne		
Dermatitis		
Dry Skin		
Itching / Rash		
Keloids		
Skin Ulcers		
Neurological		
Confusion		
Headaches		
Tremors		
Psychiatric		
Feel Anxious / Depressed		
Insomnia		
Endocrine		
Weight Gain / Loss		

Advance Directives	**Yes**	**No**
Do you have an Advanced Directive		
Do you wish to receive additional information of Advanced Directives		

Past Medical History	**Yes**	**No**
Anxiety		
Arthritis / Gout		
Bleeding / Clotting Problems		
Colon Cancer / Colon Polyps		
Congestive Heart Failure		
Depression		
Diabetes		
Emphysema/asthma		
Gallstones		
Heart Attack / MI		
Hepatitis		
High Blood Pressure		
High Cholesterol		
HIV		
IBD		
Kidney Disease		
Lupus		
Lymphedema		
Other Cancer		
Peripheral Vascular Disease		
Positive TB Test		
Renal Disease		
Scleroderma		
Seizures		
STD		
Stroke		
Thyroid Disease		

Family Medical History

Please mark: ***F*** *-Father* ***M*** *-mother* ***B*** *- brother* ***S*** *-sister* ***G*** *-Grandparent*

Alcohol abuse		
Autoimmune disease		
Cancers		
Diabetes		
Heart Disease		
High Blood Pressure		
High Cholesterol		
Kidney Problems		
Liver Cirrhosis		
Lung Problems		
Psychiatric disease		
Stroke		

Procedure History		
Cataract / Laser Eye surgery		
Circulation tests done on your legs		
Heart surgery		
Hysterectomy		
Orthopedic surgery		
GI Endoscopy (Colonoscopy / EGD)		
Liver Biopsy		
Ultrasound		

Social History

Have you ever smoked		
Do you drink alcohol		
Taken illegal drugs		

Medications Currently Taking

Drug name	*Dosage*	*Frequency*