

NEW PATIENT INFORMATION FORM

Patient : _____
Date: _____

Ht: _____ Wt: _____
BP: _____ / _____
Pulse: _____

HISTORY

CHIEF COMPLAINT: _____

HISTORY of PRESENT ILLNESS:

* Location _____ * Quality _____
* Severity _____ * Duration _____
* Timing _____ * Context _____
* Signs/Symptoms _____ * Modifying factors _____

MEDICAL HISTORY

*Patient Medical History

DiabetesNo Yes
HypertensionNo Yes
CancerNo Yes
StrokeNo Yes
Heart troubleNo Yes
Arthritis/GoutNo Yes
ConvulsionsNo Yes
Bleeding tendency ...No Yes
Acute infectionsNo Yes
Venereal diseaseNo Yes
Hereditary defects ...No Yes
Psychiatric treatment No Yes

Previous Hospitalizations/Surgeries/Injuries

Medications, Vitamins, Minerals

Allergies to medicine, food, environment

*Patient Social History

Marital status: Single___ Married___ Separated___ Divorced___ Widowed___
Use of alcohol: Never___ Rarely___ Moderate___ Daily___
Use of tobacco: Never___ Previously, but quit___ Current packs/day___
Use of drugs: Never___ Type/frequency_____
Excessive exposure at home or work to: Fumes___ Dust___ Solvents___
Air-borne particles___ Noise___

*Employment_____

*Family Medical History

| | <u>AGE</u> | <u>DISEASES</u> | <u>DECEASED/CAUSE</u> |
|----------------------|------------|-----------------|-----------------------|
| Father | _____ | _____ | _____ |
| Mother | _____ | _____ | _____ |
| Siblings | _____ | _____ | _____ |
| | _____ | _____ | _____ |
| Grandparent\children | _____ | _____ | _____ |
| | _____ | _____ | _____ |
| | _____ | _____ | _____ |
| | _____ | _____ | _____ |