

**New patient information form**

Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_ Age: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Sex: \_\_\_\_\_

Family Doctor: \_\_\_\_\_ Doctor's phone # \_\_\_\_\_

**Medical History:**

Diabetes	Yes	No	Previous Hospitalizations/Surgeries	When?
Hypertension	Yes	No	_____	
Cancer	Yes	No	_____	
Stroke	Yes	No	_____	
Heart trouble	Yes	No	_____	
Seizures	Yes	No	_____	
Kidney disease	Yes	No	_____	
Bleeding problems	Yes	No	_____	
Stomach ulcer	Yes	No		
Asthma	Yes	No	Tetnus shot Yes No _____ date	

Other \_\_\_\_\_

Medications: \_\_\_\_\_ Dose \_\_\_\_\_ Reason Taking \_\_\_\_\_

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_

**Allergies: (include reaction)**

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_

Do you have any problems with latex or tape? Yes No

**Social History:**

Exercise:  Never  Rarely  Monthly  Weekly  Daily

Type of exercise \_\_\_\_\_

Use of alcohol:  Never  Rarely  Moderate  Daily

Use of tobacco products:  Never  Previously, but quit current packs/day \_\_\_\_\_

Use of drugs:  Never Type/Frequency \_\_\_\_\_

**Family History:**

	<u>Age</u>	<u>Diseases</u>	<u>If deceased, cause of death</u>
Father	_____	_____	_____
Mother	_____	_____	_____
Siblings	_____	_____	_____
Spouse	_____	_____	_____
Children	_____	_____	_____

**Review of Systems:**

Are you currently having or have you had problems with your:

	Circle	Describe all Yes responses
Eyes	No Yes	_____
Ears, Nose, Throat	No Yes	_____
Lungs, Breathing	No Yes	_____
Digestion	No Yes	_____
Bowel Movements	No Yes	_____
Bladder Problems	No Yes	_____
Diabetes problems	No Yes	_____
High Blood Pressure	No Yes	_____
Bleeding Problems	No Yes	_____
Balance Problems	No Yes	_____
Numbness/Tingling	No Yes	_____
Blackout/Fainting	No Yes	_____
Psychological	No Yes	_____
AIDS	No Yes	_____
Cancer	No Yes	_____
Arthritis	No Yes	_____
Polio	No Yes	_____
TB	No Yes	_____
Epilepsy	No Yes	_____
Skin / Rashes	No Yes	_____

Patient signature: \_\_\_\_\_

Date: \_\_\_\_\_

Reviewed by: \_\_\_\_\_

Date: \_\_\_\_\_