New Patient Form

Patient Full Name: ____ Date of Birth _____/_____/____ Gender _____

Phone: (_____)______________________ Email: ____ Ht: _____ Wt: ______

Address: ____City_____________________ State____ Zip_______

Referring Physician: _________________________________ Primary Care: ____

Pharmacy Name: ____ Phone: ____

Reason for Visit: ____ Date of Injury: ___________ Pain Scale (1-10): ____

Allergies

List Drug Allergies and Reactions: None ____

____

Medications: Name, Strength, Dose

Please list below or provide list to staff

Medicine	Dose	#/ Day	Medicine	Dose	#/ Day

Have you had a pneumonia vaccine? ____ No ____ Yes If yes, date of vaccine: ___________________________________

Have you had a Flu Shot in the last year? ____ No ____ Yes If yes, date of shot:____________________________________

Have you had any falls in the last year? ____ No ____ Yes If yes, how many: _____ Were you injured? ___ No ___ Yes

Family History

Please list any blood relatives (Mother, Father, Siblings) that have had any of the following:

Arthritis: __________________________ Bleeding Problems: _____________________ Stroke: ____________________

Heart Disease: ____________________ Diabetes: _______________________________ Cancer: ___________________

High Blood Pressure: _______________ Kidney Disease: __________________________ Other: ____________________

Social History

Occupation: ________________________________ Marital Status: SINGLE MARRIED WIDOWED OTHER

Dominate hand: RT LT Recreational Drugs: YES NO Alcohol: NEVER RARELY WEEKLY DAILY

Tobacco Use: YES NO QUIT Year Quit: ______ # Packs/Day: ____ # Years: ___ Chewing Tobacco: YES NO

Age of Menopause: ___________ Current Hormone Therapy: YES NO

Past Surgeries

List Surgery Type, Date, and Physician who performed the surgery:

____ ____

____ ____

____ ____

Past Medical History

ADD/ADHD	Alzheimer's Disease	Anemia	Anxiety
Arthritis	Asthma	Bipolar	Bleed or Bruise Easily
Bleeding Disorder	Blood Clots	Emphysema/COPD	CPAP
Cancer	Cardiac Defib	Chest Pain/Angina	Chronic Back Pain
Claustrophobia	Stomach Ulcers/Colitis	Congestive Heart Failure	Defibrillator
Depression	Diabetes	Dizziness	Drug Dependency/Abuse
Enlarged Glands	Excessive Thirst	Eye Disease/Cataracts/Glaucoma	Fibromyalgia
GERD/Reflux	GI Issues	Gout	HIV/AIDS
Headaches	Heart Attack	Heart Problems	Hepatitis/Liver Disease
High Cholesterol	Hypertension	Irregular Heartbeat	Joint Pain
Kidney Disease	Leukemia	Loss of Consciousness	Lung Disease
Lupus/SLE	MRSA	Migraines	Mouth Sores
Numbness/Tingling	Osteoarthritis	Osteoporosis	Pacemaker
Parkinson's Disease	Poor Circulation	Previous Cortisone Injection	Previous Fracture
Psoriasis	Pulmonary Embolism	Previous Oral Steroid	Rheumatoid Arthritis
Seizures/Epilepsy	STD	Sickle Cell Anemia	Sleep Apnea
Spitting up Blood	Stroke	Swelling of Legs/Feet/Hands	Thyroid Disorder
Tuberculosis	Urinary Infection	Weight Loss	Change in Hair or Nails

Review of Systems

Please check any of the below that you have had in the last month.

Constitutional:	Fever	Significant Weight Loss/Gain - How many pounds? ______		
Heent:	Dry Eyes	Eye Irritation	Vision Changes	Sore Throat
Cardiovascular:	Chest Pain	Palpitations	Poor Circulation	Leg Swelling
Respiratory:	Cough	COPD	Asthma	Shortness of Breath
Gastrointestinal:	Vomiting Nausea	Blood in Stool Constipation	Diarrhea	Vomiting Blood
Genitourinary:	Blood in urine	Difficulty Urinating	Burning during urination	
Musculoskeletal:	Joint Pain	Swelling in Joints	Rheumatoid Arthritis	Height Loss of 2 inches or more
Skin:	Rash	Varicose Veins		
Neurologic:	Numbness Tingling	Seizures	Dizziness	Difficulty with Balance
Psychiatric:	Anxiety	Depression		
Endocrine (Temperature Intolerance):		To Heat		
Hematologic/ Lymphatic:	Anemia	Swollen Glands	Bruising	Bleed Easily

Patient Signature: ____ Date: _______________________