NEW PATIENT INFORMATION FORM

Patient_____ Date:_____

DRUG ALLERGIES:_____

HISTORY:

Chief Complaint:_____

History of Present Illness:

Location_____
(where is the pain/problem?)

Severity_____
(How severe is the pain/problem?)

Timing_____
(Does this pain/problem occur at a specific time?)

Duration_____
(How long have you had this pain/problem? or when did it start?)

Associated signs/symptoms_____

_____
(What other associated problems have you been having?)

Modifying Factors:_____
(What makes the pain/problem worse or better? or Have you had any previous episodes?)

MEDICAL HISTORY:

Patient medical history:

Diabetes	No	Yes
Hypertension	No	Yes
Cancer	No	Yes
Stroke	No	Yes
Arthritis/Gout	No	Yes
Seizure Disorder	No	Yes
Liver Disease	No	Yes
Stomach/Colon Disease	No	Yes
Blood Clots	No	Yes
Kidney Disease	No	Yes
Lung Disease/Asthma	No	Yes
Heart Trouble	No	Yes
Thyroid Problems	No	Yes
Cholesterol Elevation	No	Yes

Other:_____
_____
_____

Previous Hospitalizations/surgeries/serious injuries: When?

_____
_____
_____
_____
_____

Medications:

_____
_____
_____
_____
_____
_____

Vaccines: __Flu Yr. Received_____
__Tetanus Yr Received_____
__Pneumonia Yr Received_____
__Hepatitis Yr Received_____

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 pack/day
Use of drugs: __Never If yes, type and frequency:_____
Excessive exposure at home or work to: __Fumes __Dust __Air-borne particles __Pets
Occupation:_____

Family Medical History:

	Age	Disease	If deceased, cause of death and age
Father	____	_____	_____
Mother	____	_____	_____
Brothers	____	_____	_____
	____	_____	_____
Sisters	____	_____	_____
	____	_____	_____
Children	____	_____	_____
	____	_____	_____
	____	_____	_____