Date: _____ **New Patient History** Revised: 2/12/15

Patient: _____ DOB:_____ Gender: M[ ] F[ ] Race:_____

Active Specialist/Speciality: _____/_____ _____/_____
_____/_____ _____/_____

Review of Systems – Check if patient currently has any of the following.

Chills or Fever [ ]	Chest Pain(respiratory) [ ]	Stomach Pain [ ]	Abnormal Walking [ ]	Asthma [ ]
Night Sweats [ ]	Shortness of Breath [ ]	Loss of Appetite [ ]	Seizures [ ]	Food Allergies [ ]
Recent Weight Change [ ]	Heart/Chest Pain [ ]	Nausea / Vomiting [ ]	Skin Lesion/ Rash [ ]	Seasonal Allergies [ ]
Poor Appetite [ ]	Leg Swelling [ ]	Difficulty Urinating [ ]	Easy Bleeding [ ]	
Loss of Hearing [ ]	Abnormal Heartbeat [ ]	Blood in Urine [ ]	Easy Bruising [ ]	
Change of Vision [ ]		Urinary Incontinence [ ]		

Medical / Surgical History – Check if patient has any of the following.

AIDS/HIV [ ]	Blood Clots/ Phlebitis [ ]	Gout [ ]	Liver Trouble [ ]	Thyroid Trouble [ ]
Alcoholism [ ]	Cancer [ ] _____	Heart Disease [ ]	Mental Illness [ ]	Tuberculosis [ ]
Alzheimer's [ ]	COPD [ ]	Hepatitis [ ]	Osteoarthritis [ ]	Ulcers [ ]
Arthritis [ ]	Depression [ ]	High Cholesterol [ ]	Osteoporosis [ ]	Fractures [ ]
Asthma [ ]	Diabetes [ ]	Hypertension [ ]	Parkinson Disease [ ]	Other [ ]
Bleeding Disorders [ ]	Drug Abuse [ ]	Kidney Disease [ ]	Stroke [ ]	

Explain answers:

_____

_____

Surgeries - List all surgeries including approximate date.

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

FEMALES ONLY - Update the following.

Gone through menopause? Y[ ] N[ ]
Going through menopause? Y[ ] N[ ]
Is it possible you are pregnant? Y[ ] N[ ]
Have you had a hysterectomy? Y[ ] N[ ]

Medications - List all active medications. **Pharmacy:** _____ **NONE [ ]**

_____ _____ _____ _____
_____ _____ _____ _____
_____ _____ _____ _____

Allergies (to medications): **NONE [ ]**

_____ _____ _____ _____
_____ _____ _____ _____

Family History – Check if patient's family members have the following (indicate mother, father, brother, sister).

AIDS/HIV [ ]	Blood Clots/ Phlebitis [ ]	Gout [ ]	Liver Trouble [ ]	Thyroid Trouble [ ]
Alcoholism [ ]	Cancer [ ] _____	Heart Disease [ ]	Mental Illness [ ]	Tuberculosis [ ]
Alzheimer's [ ]	COPD [ ]	Hepatitis [ ]	Osteoarthritis [ ]	Ulcers [ ]
Arthritis [ ]	Depression [ ]	High Cholesterol [ ]	Osteoporosis [ ]	Fractures [ ]
Asthma [ ]	Diabetes [ ]	Hypertension [ ]	Parkinson Disease [ ]	Other [ ]
Bleeding Disorders [ ]	Drug Abuse [ ]	Kidney Disease [ ]	Stroke [ ]	

Explain answers and add cause of death of parents, brothers and sisters.

_____

_____

_____

Social History (Patient's)

Tobacco: Y[ ] N[ ] FORMERLY [ ] Packs / Day :_____ Year Quit _____
Alcohol: Y[ ] N[ ] FORMERLY [ ] Frequency : Occasional [ ] Moderate [ ] Heavy [ ]
Illicit Drugs: Y[ ] N[ ] FORMERLY [ ]

Marital Status: S[ ] M[ ] D[ ] W [ ] **Children:** None [ ] # of sons [ ] # of daughters: [ ]
Work/School: Retired? Y [ ] N[ ] Disabled? Y [ ] N[ ]
Place of Employment Occupation: _____
OR School Name: _____ Grade (Students Only): _____

PATIENT DATA DETAIL SHEET

PATIENT INFORMATION:

Name: _____ Sex:

Address: _____ Birth Date: _____

2nd Addr: _____ SSN: _____

Email: _____ Primary Care Physician: _____

Phone (order by preference)	**Type**	**Who's Phone**	**Phone Owner's Name**
_____	cell home work	self spouse parent other: _____	_____
_____	cell home work	self spouse parent other: _____	_____
_____	cell home work	self spouse parent other: _____	_____

RESPONSIBLE PARTY:

Relationship: __self __parent __guardian __other:_____ Sex:

Name: _____ Birth Date: _____

Address: _____ SSN: _____

CONTACTS: (Persons we may inform about your medical or financial information.)

Name: _____ Relationship to Patient: _____ Phone: _____

_____ _____ _____

EMERGENCY CONTACTS:

Name: _____ Relationship to Patient: _____ Phone: _____

_____ _____ _____

INSURANCE INFORMATION:

Primary: _____ Insured: _____ Birth Date: _____

Secondary: _____ _____ _____

CENSUS INFORMATION: (The federal government requires physician groups to collect certain information. You are not requried to provide this and may DECLINE to answer.)

Ethnicity	**Race**		**Preferred Language**	
__Decline	__Decline		__Decline	
__Hispanic or Latino	__Asian	__Black or African American	__English	__Japanese
__Not Hispanic or Latino	__Hispanic	__American Native or Alaskan Native	__Chinese	__Korean
	__White	__Native Hawaiian or Other Pacific Islander	__French	__Russian
	__Other		__German	__Other

VISIT INFORMATION:

Describe how you were injured or where pain orginates: _____

Date/Time of Injury or Date Pain Began: ___/___/___ , ___:___ AM / PM

Where did injury occur? __at home __at work __in an auto accident __other: _____

Did another physician refer you here for this problem? __Y __N If yes, physician's name: _____

Did you have x-rays or other tests for this problem? __Y __N If yes, where were they taken? _____

Signature of patient / guardian: _____ Date: _____

Printed name of patient / guardian: _____