Name: _____ **Dr: _____**
Date: _____

NEW PATIENT HISTORY FORM

(*Please complete this form and fax to 806-356-0045 a few days prior to your appointment*.)

CHIEF COMPLAINTS

- 1._____ 3._____
- 2._____ 4._____

MEDICATIONS	DOSAGE	FREQUENCY	DOCTOR
1._____	_____	_____	_____
2._____	_____	_____	_____
3._____	_____	_____	_____
4._____	_____	_____	_____
5._____	_____	_____	_____
6._____	_____	_____	_____
7._____	_____	_____	_____

PAST MEDICAL HISTORY (*please circle if applied)*		DATE
1.	*Heart Disease/Heart Attack*	_____
2.	*High blood pressure*	_____
3.	*Irregular heart rhythm/atrial fibrillation*	_____
4.	*Enlarged heart*	_____
5.	*High cholesterol*	_____
6.	*Diabetes (Type I/Type II)*	_____
7.	*Kidney disease*	_____
8.	*Thyroid disease (high/low)*	_____
9.	*Lung disease (asthma/emphysema)*	_____
10.	*Arthritis (osteoarthritis/rheumatoid)/Lupus/Gout/Scleroderma*	_____
11.	*Leg swelling*	_____
12.	*Blood disorder (bleeding disorder/blood clot)*	_____
13.	*Peptic ulcer disease*	_____
14.	*Osteoporosis/Osteopenia*	_____
15.	*Erectile dysfunction*	_____
16.	*Low testosterone*	_____
17.	*Multiple sclerosis*	_____
18.	*Stroke (embolic/hemorrhagic)*	_____
19.	*Headache (migraine/tension/cluster)*	_____

- ♦ *20. Alcohol/Tobacco/Drug problem* _____
- ♦ *21. Depression* _____

PAST MEDICAL HISTORY (*please circle if applied*): continued **DATE**

- ♦ *22. Irritable bowel syndrome* _____
- ♦ *23. Fibromyalgia* _____
- ♦ *24. Neuropathy* _____
- ♦ *25. Glaucoma* _____
- ♦ *26. Cataract* _____
- ♦ *27. Peripheral vascular diseases* _____
- ♦ *28. Cancer* _____
- ♦ *29. Parkinson disease* _____
- ♦ *30. Gallstones* _____

PAST SURGICAL HISTORY **DATE**

- ♦ *1. Heart surgery/Angioplasty/Stent* _____
- ♦ *2. Gallbladder* _____
- ♦ *3. Appendectomy* _____
- ♦ *4 Peptic ulcer* _____
- ♦ *5. Tonsillectomy* _____
- ♦ *6. Shoulder scope/surgery (R/L)* _____
- ♦ *7. Hip replacement (R/L)* _____
- ♦ *8. Knee scope/replacement (R/L)* _____
- ♦ *9. Ankle (R/L)* _____
- ♦ *10. Vasectomy* _____
- ♦ *11. Prostate surgery (cancer/enlarged prostate)* _____
- ♦ *12. Kidney stone removal/Lithotripsy* _____
- ♦ *13. Cataract (R/L)* _____
- ♦ *14. Carotid Surgery (R/L)* _____
- ♦ *15. Aorto–bifemoral bypass* _____
- ♦ *16. Colonoscopy/Upper endoscopy* _____
- ♦ *17. Thyroid/Parathyroid* _____
- ♦ *18. Carpal tunnel release (R/L)* _____
- ♦ *19. Breast augmentation/reduction* _____
- ♦ *20. Colon resection* _____
- ♦ *21. Vein Stripping* _____
- ♦ *22. Bladder suspension* _____
- ♦ *23. Hysterectomy with/without removal of (R/L) ovaries/Tubal ligation* _____
- ♦ *24. Neck/back surgery* _____
- ♦ *25. Kyphoplasty* _____
- ♦ *26. Mastectomy (R/L)* _____

- *27. Amputation (above/below R/L knee)* _____
- *28. Blood transfusion* _____
- *29. D & C* _____

GYNECOLOGICAL HISTORY (*gynecologist's name*) Dr _____

- *1. Number of children: son ( ); daughter ( )*
- *2. Number of abortion (none/ _____)*
- *3. Last menstrual cycle:_____*
- *4. Last mammogram:_____*
- *5. Last pap smear:_____*
- *6. Sexual transmitted disease (type):_____*

FAMILY HISTORY	**AGE**	**DISEASES**
1. Father (alive/dead)	_____	_____
2. Mother (alive/dead)	_____	_____
3. Paternal grandfather (alive/dead)	_____	_____
4. Paternal grandmother (alive/dead)	_____	_____
5. Maternal grandfather (alive/dead)	_____	_____
6. Maternal grandmother(alive/dead)	_____	_____
7. Brothers:	_____	_____
8. Sisters:	_____	_____
9. Sons:	_____	_____
10. Daughters	_____	_____

SOCIAL HISTORY (*be specific; please circle if applied*)

- *1. Marital status: engaged/married/widowed/separated/divorced/single*
- *2. Occupation:_____*
- *3. Spouse occupation:_____*
- *4. Tobacco use:_____*
- *5. Alcohol use:_____*
- *6. Caffeine use:_____*
- *7. Drug use:_____*
- *8. Sexually active (heterosexual/homosexual): _____*
- *9. Exercise:_____*

HEALTH MAINTENANCE/IMMUNIZATIONS	**DATE**
1. Pneumonia vaccine	_____
2. Tetanus booster	_____
3. Flu vaccine	_____
4. Shingles vaccine	_____

- *5. Hepatitis A* _____
- *6. Hepatitis B* _____
- *7. Meningococcal vaccine* _____
- *8. Last bone density test* _____
- *9. Last colonoscopy* _____
- *10. Last diabetic eye exam (Dr.)* _____
- *11. Last chest X-ray* _____
- *12. Last EKG* _____
- *13. Last stress test* _____
- *14. Last PSA* _____
- *15. Last fecal occult test* _____

REVIEW OF SYSTEMS (*Please circle if applied*)

1. **General**

   - *Weight loss/gain_____ Fatigue Decreased appetite*
   - *Night sweat Fever/chills Insomnia*

2. **Skin**

   - *Itchiness Rash Hair loss/growth Mole Nail change*

3. **Head/Eyes/Ears/Nose/Throat**

   - *Headache Blurry vision Red/itchy eyes Hearing loss*
   - *Ear Ringing/pain Nasal drainage Nose bleed Sinus pressure*

4. **Cardiovascular**

   - *Chest pain/tightness Palpitations Short of breath (lying/walking)*
   - *Leg pain with walking High blood pressure Dizziness*

5. **Respiratory**

   - *Shortness of breath Wheezing Cough (with/without sputum)*
   - *Cough (blood) Pain with inspiration Trauma to chest*

6. **Gastrointestinal**

   - *Nausea Vomiting Diarrhea Constipation Bleeding*
   - *Heartburn Hemorrhoids Abdominal pain Bloating*
   - *Painful Swallowing Difficult Swallowing*

7. **Genitourinary**

- *Painful urination* *Frequency urination* *Blood in urine*
- *Incontinence with cough/sneezing* *Urination at night ( )*
- *Slow stream* *Dribbling* *Decreased libido*
- *Erectile dysfunction* *Penile/Vaginal discharge* *Bleeding*

8. **Breasts**

- *Nipple inversion* *Nipple discharge ( )* *Mass/Lump*
- *Monthly self-breast exam (yes/no)* *Pain*

9. **Musculoskeletal**

- *Joint Pain* *Stiffness* *Joint swelling* *Muscle pain*
- *Neck pain* *Back pain* *Shoulder pain* *Wrist pain*
- *Knee pain* *Ankle pain* *Muscle weakness ( )*

10. **Neurological**

- *Headache* *Dizziness* *Pass-out* *Short-term memory loss*
- *Seizures* *Head injury* *Tremor* *Confusion*
- *Loss of sensation* *Sense of imbalance* *Falling*

11. **Endocrine**

- *Heat/cold intolerance* *Sweating* *Drinking/eating excessively*
- *Increased urination*

12. **Hematological**

- *Easy bruising* *Easy bleeding* *Blood clot*
- *Anemia* *Low white count* *Low platelet count*

13. **Psychiatric**

- *Suicidal ideation* *Homicidal ideation* *Decreased interest*
- *Feeling hopeless/depressed* *Anxiety* *Memory loss* *Irritability*

14. **Others**

- _____

Please list all the current physicians involved in your medical care.

_____ _____ _____