NEW PATIENT HISTORY

CHART # _____

Name: _____ Date: _____
(Last) (First) (Middle)

Date of Birth: _____ Age: _____ Primary Doctor: _____

Do You Have Any Medication Allergies? Yes ( ) No ( ) If Yes, Please List With Type Of Reaction:

_____

_____

PLEASE LIST ALL THE PRESCRIPTION AND NON-PRESCRIPTION MEDICATIONS YOU ARE CURRENTLY TAKING:

MEDICATIONS / DOSE (mg) / FREQUENCY	MEDICATIONS / DOSE (mg) / FREQUENCY
1.	**11.**
2.	**12.**
3.	**13.**
4.	**14.**
5.	**15.**
6.	**Changes No / Yes :**
7.	
8.	
9.	
10.	

PLEASE INDICATE WHETHER OR NOT YOU HAVE HAD ANY OF THE FOLLOWING CONDITIONS:

INDICATE:	YES	NO	INDICATE:	YES	NO
Chest Pain / Angina			Gout		
Coronary Artery Disease			Dizziness / Fainting		
Heart Murmur			Epilepsy		
Heart Attack			Anxiety		
Bypass Surgery			Glaucoma / Eye Disorders		
Angioplasty (Balloon)			Thyroid Disease or Problem		
Heart Rhythm Disturbance			Shortness of Breath		
Stent			Asthma		
Heart Valve Surgery			COPD / Emphysema		
Carotid Blockage			Peptic Ulcer		
Leg Circulation Problems			Pancreatitis		
Stroke / TIA			Gallbladder Disease		
Congenital Heart Disease			Liver Disease, Jaundice, Hepatitis		
Rheumatic Heart Disease			Intestinal Problems (Colitis), Etc.		
Congestive Heart Failure			Kidney Disease		
Heart Palpitations			Urinary Problems		
Leg Pain While Walking			Fatigue		
Aneurysm			Anemia		
Pacemaker or Defibrillator			Bleeding Disorder		
High Cholesterol			Arthritis		
High Triglycerides			Cancer		
High Blood Pressure			HIV/ AIDS		
Diabetes			Psychiatric Problems		
Abdominal Pain / Fullness			Fever / Chills / Sweats		
Mitral Valve Prolapse			Lower Extremity Swelling		

OTHER: (PLEASE MAKE ANY COMMENTS IN REGARDS TO THE ABOVE):

_____

_____

_____

SURGERIES / HOSPITALIZATIONS

REASON FOR HOSPITALIZATION / SURGERY	DATE(S)	NAME OF HOSPITAL

GYNECOLOGICAL HISTORY (WOMEN ONLY):

Have you gone through menopause? YES ( ) NO ( )

Have you had a hysterectomy? YES ( ) NO ( )

Do you take hormone replacement? YES ( ) NO ( )

CHRONIC MEDICAL PROBLEMS (PLEASE LIST):

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

OTHER MEDICAL PROBLEMS / CONCERNS YOU MAY HAVE: _____

_____

_____

PERSONAL:

OCCUPATION: _____ MARITAL STATUS: _____ CHILDREN: _____

1) Do you smoke? YES ( ) NO ( ) QUIT ( ) If you quit, how long ago? _____
   If "yes" or "quit", how much do (or did) you smoke per day? _____
   How long have (or had) you been smoking? _____
2) Do you drink alcoholic beverages? YES ( ) NO ( )
   If "yes", how many drinks do you average per week? _____ Liquor _____ Wine _____ Beer
3) Do you use (or have you used) illegal drugs? YES ( ) NO ( )
   Do you use (or have you used) intravenous drugs? YES ( ) NO ( )
   Date last used: _____
4) Do you exercise regularly? YES ( ) NO ( ) How long / often? _____
   What do you do? _____ How long? _____ How often? _____
5) How much caffeine do you consume daily? (cup of coffee, tea, soda) _____
6) Do you have a living will or an advance directive? YES ( ) NO ( )

FAMILY HISTORY:

HAVE ANY OF YOUR FAMILY MEMBERS HAD ANY OF THE FOLLOWING PROBLEMS?

Please use M (Mother), F (Father), GM (Grandmother), GF (Grandfather), S (Sister), B (Brother), C (Children), A (Aunts), U (Uncles)

PROBLEM	*FAMILY MEMBER / MEMBERS AND AGE OF ONSET FOR EACH*
Stroke	
Heart Attack	
Heart Bypass	
Angioplasty / Stent	
Diabetes	
High Blood Pressure	
Cholesterol / Triglycerides	
Leg Circulation Problems	
Carotid (Neck) Blockage	
Pacemaker	

PLEASE ADD ANY PERTINENT FAMILY HISTORY: _____

_____

_____

_____