Welcome to Our Practice

As a new patient, please fill out the information found below to the best of your ability.

Patient # _____ Physician _____ Date _____

Patient name _____ Chief complaint _____

History of Present Illness:

Location _____
(Where is the pain/problem?)

Quality _____
(Example: normal versus abnormal color, activity, etc.)

Severity _____
(How severe is the pain/problem on a scale of 1-5 [5 being the most severe])

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

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

Context _____
(Where were you at the onset of this pain/problem?)

Associated Signs/ Symptoms _____
(What other associated problems have you been having?)

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

Patient Medical History:

Have you ever had the following (check "no" or "yes", leave blank if uncertain):

Measles	☐ No	☐ Yes	Venereal Disease	☐ No	☐ Yes	Blood or Plasma Transfusions	☐ No	☐ Yes	Mitral Valve Prolapse	☐ No	☐ Yes
Mumps	☐ No	☐ Yes	Anemia	☐ No	☐ Yes	Back Trouble	☐ No	☐ Yes	Stroke	☐ No	☐ Yes
Chickenpox	☐ No	☐ Yes	Bladder Infections	☐ No	☐ Yes	High or Low Blood Pressure	☐ No	☐ Yes	Hepatitis	☐ No	☐ Yes
Whooping Cough	☐ No	☐ Yes	Epilepsy	☐ No	☐ Yes	Hemorrhoids	☐ No	☐ Yes	Ulcer	☐ No	☐ Yes
Scarlet Fever	☐ No	☐ Yes	Migraine Headaches	☐ No	☐ Yes	Asthma	☐ No	☐ Yes	Kidney Disease	☐ No	☐ Yes
Diphtheria	☐ No	☐ Yes	Tuberculosis	☐ No	☐ Yes	Hives or Eczema	☐ No	☐ Yes	Thyroid Disease	☐ No	☐ Yes
Smallpox	☐ No	☐ Yes	Diabetes	☐ No	☐ Yes	AIDS or HIV+	☐ No	☐ Yes	Bleeding Tendency	☐ No	☐ Yes
Pneumonia	☐ No	☐ Yes	Cancer	☐ No	☐ Yes	Infectious Mono	☐ No	☐ Yes	Any Other Disease (please list)	☐ No	☐ Yes
Rheumatic Fever	☐ No	☐ Yes	Polio	☐ No	☐ Yes	Bronchitis	☐ No	☐ Yes			
Heart Disease	☐ No	☐ Yes	Glaucoma	☐ No	☐ Yes	Date of last chest x-ray: _____					
Arthritis	☐ No	☐ Yes	Hernia	☐ No	☐ Yes						

Previous Hospitalizations/Surgeries/Serious Illnesses

	When	Hospital, city, state

Medications (include nonprescription):

_____

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 packs/day _____	
Use of drugs:	☐ Never	☐ Type/frequency: _____			
Excessive exposure at home or work to:	☐ Fumes	☐ Dust	☐ Solvents	☐ Airborne particles	☐ Noise

Family Medical History:

	Age	Diseases	If deceased, cause of death
Father			
Mother			
Siblings			
Spouse			
Children			

Over Please