

NEW PATIENT INFORMATION SHEET

Date _____

Name _____ Email Address: _____

Address _____

Home Phone _____ Cell Phone _____ Date of Birth _____

Please answer all questions accurately and completely. We will not release this information without your authorization

List ALL diseases you are presently receiving treatment for, and any serious illnesses you have had in the past _____

List ALL medications you presently take regularly or occasionally, prescription, and non-prescription. Include dose and frequency.

Are you allergic to any medications? Please list them plus your bad reaction _____

Have you ever been hospitalized? List date(s), reason(s), and treatment(s) _____

Have you ever had an operation? List date(s) and procedure(s) _____

Have you ever had a blood transfusion? Please list dates _____

How many alcoholic beverages do you consume in a week? _____ month? _____

Do you smoke or chew tobacco? How much? _____

How much caffeine do you consume per day? _____

What illnesses run in your family?

Mother _____

Father _____

Brothers/Sisters _____

Children _____

Circle **any** of the following diseases in your blood relatives:

- | | | | | | |
|----------------------|--------|--------------|----------------------|----------------------|---------------------|
| Arthritis/Rheumatism | Asthma | Cancer | Diabetes | Heart trouble | High Blood Pressure |
| Kidney trouble | Ulcer | Tuberculosis | Psychological issues | Epilepsy/convulsions | |
| Bleeding tendencies | Stroke | Anemia | | | |

Are you married? _____ How long have you been married? _____

Circle the highest form of education you've received:

Elementary School _____ High School years _____ College years _____ Graduate School years _____

Present Occupation? _____

Religious affiliation _____

Are you having problems with any of the following? Please circle all the listed problems you have currently or diseases you have had in the past.

Weakness, fatigue, changes in weight (how much and over what period of time) _____ change in appetite, sleep too much, sleep too little, chills, fever, night sweats.

Change in skin color, itching, lumps on skin, skin infections, skin tumors, hair changes.

Anemia, abnormal bleeding, enlarged lymph glands, excessive bruising.

Headache, passing out, seizure/convulsions, double vision, paralysis/limb weakness, tremor, difficulty walking, abnormal sensation.

Date of last eye exam _____, glasses, contact lenses, difficulty with vision, other eye diseases _____

Decreased hearing, ringing in ears

Abnormal nosebleeds, recurrent earaches, nasal discharge, recurrent sinus infections, change in voice, lumps in neck.

Tooth cavities, dentures (partials/complete, upper/lower), dental disease

Breast lump, breast cancer, breast discharge, breast pain

Asthma, frequent cough, change in cough, bloody phlegm, wheezing, recurrent respiratory infections, positive tuberculosis test

Chest pain, shortness of breath, difficulty breathing at night, ankle swelling, heart murmur, palpitations, heart attack, heart surgery

High blood pressure, blood clots, varicose veins

Recurrent nausea/vomiting, recurrent diarrhea, significant constipation, black tarry bowel movements, rectal bleeding, change in bowel habits, hemorrhoids, significant abdominal pain, jaundice, use of antacids, use of laxatives, ulcer, intestinal tumor, diverticulosis.

Painful urination, blood in urine, increased frequency of urination, difficulty starting urine stream, difficulty controlling urine, kidney stones, urinary tract infections.

Joint pain, swelling, or stiffness. Joint deformity, muscle aches.

Thyroid disease, goiter, intolerance of heat/cold, diabetes

Depression, difficulty sleeping, nightmares, memory loss, thoughts of suicide

MALE penile discharge, lesion, venereal disease, testicular pain, testicular mass, infertility, difficulty with erections, decreased sexual desire,

Sexually active, erectile dysfunction, method of birth control _____

FEMALE age at first period _____, last menstrual cycle _____, age at menopause _____

Irregular periods or abnormal vaginal bleeding, vaginal discharge, venereal disease, last abnormal pap smear _____

Bleeding after menopause, hysterectomy, removal of ovaries-one/both, decreased sexual desire. Number of pregnancies _____

Full term deliveries _____, miscarriages/stillbirths _____ abortions _____, living children _____

Complications of pregnancies, Cesarean sections, infertility.

List your present method(s) of birth control _____