

New Patient Medical and Personal History

Name:

Date: (mm/dd/yyyy)

Age:

For what reason are you here today? (Only what appears in the box will be printed)

Please check conditions you have had:

Asthma	Congestive Heart Failure	Prostate Disease	Cancer (where?)
Emphysema	Heart Murmur	Hepatitis	Serious Infections (e.g. pneumonia)
Allergic Rhinitis	Heart Valve Disease	Cirrhosis of the Liver	Endometriosis
Eczema	Stroke	Stomach Ulcers	Sexually Transmitted Infections
Psoriasis	Blood Clots in Lungs	Ulcerative Colitis	Rheumatoid Arthritis
HIV Infection	Blood Clots in Veins	Crohns Disease	Degenerative Joint Disease
Diabetes Mellitus	Rheumatic Fever	Irritable Bowel Disease	Fibromyalgia
Hypertension	Angina	Bleeding from Intestines	Systemic Lupus Erythematosus
Thyroid Goiter	Heart Attack	Diverticulosis	Fibrocystic Breas t Disease
Hyperthyroidism	Heart Arrhythmia	Diverticlitus	Chronic Vertigo (Meniere's)
Hypothyroidism	Atrial Fibrillation	Gall Stones	Frequent Sinus Infections
Kidney Stones	Multiple Sclerosis	Pancreatitis	Osteoporosis
Transfusions	Peripheral Nerve Disease	Colon Polyps	
Glaucoma	Migrane Headaches	Frequent Ear Infections	

Doctor Notes:

Please indicate any surgeries you have had and the year you had them:

Year	Year	Year	Year
Gall Bladder	Carotid Artery	Hip	Trauma Related
Inguinal Hernia	Other Vascular	Knee	Back or Neck
Angioplasty	Coronary Bypass	Stomach	Urinary Incontinence
Thyroid	Chest/Lung	Appendectomy	Hysterectomy C-Section
Ear	Sinus	Mastectomy	Other Breast
Neurosurgery	Carpal Tunnel	Prostate	Tonsillectomy

Doctor Notes:

Please indicate when you have had any of the following preventative tests or services:

Year	Year	Year	Year
Mammogram	Rectal Exam	Flu Vaccine	Cardiac Angiogram
Pap Smear	Prostate Cancer Blood Test	Pneumonia Vaccine	Stress Test
Breast Exam	Colon Cancer Stool Test	Tetanus Vaccine	Echocardiogram
Chest X-ray	Flexible Sigmoidoscopy	Hepatitis Vaccine	Date of Last Physical Exam
EKG	Barium Enema	Bone Density Test	

Doctor Notes: