New Patient Information Form

Patient Name _____ **Date** _____

Date of Birth _____

Chief Complaint: _____

Location _____ **Severity** _____ (where is the pain/problem) (how sever is the pain/problem)

Duration _____ **Timing** _____ (how long have you had pain) (does this pain occur at specific times)

Associated Symptoms _____ **Modifying Factors** _____

_____ _____

(what other problems are you having) (what causes the pain/problem to worsen/better. Previous episodes)

PATIENT MEDICAL HISTORY

Have you had, or do you have, any of the following medical problems:

Diabetes	No	Yes
Hypertension	No	Yes
Breast Cancer	No	Yes
Colon Cancer	No	Yes
Other Cancer	No	Yes
Stroke	No	Yes
Arthritis	No	Yes
Convulsions	No	Yes
Bleeding tendency	No	Yes
Acute Infections	No	Yes
Venereal disease	No	Yes
Abnormal PAP	No	Yes
Hepatitis/Jaundice	No	Yes
Liver/Pancreas disease	No	Yes
Kidney Stones	No	Yes
Urinary Tract infection	No	Yes
Sickle Cell	No	Yes
Anemia	No	Yes
Received Blood transfusion	No	Yes

Heart Surgery	No	Yes
Heart Attack	No	Yes
Angioplasty	No	Yes
Pacemaker/AICD	No	Yes
Stent	No	Yes
Cardiac Arrest	No	Yes
Congestive Heart Failure	No	Yes
Valvular disease	No	Yes
Asthma	No	Yes
Emphysema	No	Yes
Tuberculosis	No	Yes

PREVIOUS HOSPITALIZATIONS/ SURGERY **Date**

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Social History: (Please check the below conditions that apply to your social history)

☐ Tobacco Use If yes: ☐ Light/Social ☐ Heavy/Everyday ☐ Former Use

☐ Alcohol Use If yes: ☐ Light/Social ☐ Heavy/Everyday ☐ Former Use

☐ Drug Use (Recreational or IV)

If you are 65 years or older, *please answer the below questions below:*

Have you fallen in the past 12 months? ☐ Yes ☐ No If yes, how many falls? _____ Injured due to fall? ☐ Yes ☐ No

Family History: ☐ *No Known Family History*

☐ Bleeding Disorder (Mother/Father) ☐ Cancer (Mother/Father) ☐ Diabetes (Mother/Father) ☐ Heart Disease Mother/Father)

☐ Hypertension (Mother/Father) ☐ Kidney Disease (Mother/Father) ☐ Stroke (Mother/Father)

☐ Other: _____