NEW PATIENT MEDICAL HISTORY

Patient Name:_____ Date of Birth:_____ Today's Date:_____

CONSTITUTIONAL SYMPTOMS:

Good general health lately	NO	YES
Recent weight change	NO	YES
Fever	NO	YES
Fatigue	NO	YES
Headaches	NO	YES

EYES:

Eye disease or injury	NO	YES
Wear glasses/contact lenses	NO	YES
Blurred or double vision	NO	YES
Glaucoma	NO	YES

EARS, NOSE, MOUTH, THROAT:

Hearing loss or ringing	NO	YES
Earaches or drainage	NO	YES
Chronic sinus problems/rhinitis	NO	YES
Nosebleeds	NO	YES
Mouth sores	NO	YES
Bleeding gums	NO	YES
Bad breath or bad taste	NO	YES
Sore throat or voice change	NO	YES
Swollen glands in neck	NO	YES

CARDIOVASCULAR:

Heart trouble or murmur	NO	YES
Chest pain or Angina Pectoris	NO	YES
Palpitations	NO	YES
Shortness of Breath	NO	YES
Swelling of feet, ankles, or hands	NO	YES

RESPIRATORY:

Chronic or frequent coughing	NO	YES
Spitting up blood	NO	YES
Shortness of breath	NO	YES
Asthma or wheezing	NO	YES

GASTROINTESTINAL:

Loss of appetite	NO	YES
Change in bowel movements	NO	YES
Nausea or vomiting	NO	YES
Frequent diarrhea	NO	YES
Painful bowel movements, constipation	NO	YES
Rectal bleeding or blood in stool	NO	YES
Abdominal pain or heartburn	NO	YES
Peptic ulcer (stomach or duodenal)	NO	YES

GENITOUINARY:

Frequent urination	NO	YES
Burning or painful urination	NO	YES
Blood in urine	NO	YES
Change in force of strain when urinating	NO	YES
Incontinence or dribbling	NO	YES
Kidney stones	NO	YES

MEN ONLY:

Testicle pain	NO	YES

WOMEN ONLY:

Age of first period	_____
# of pregnancies	_____
Age of first pregnancy	_____
Age of Menopause	_____

PSYCHIACTRIC:

Memory loss or confusion	NO	YES
Nervousness	NO	YES
Depression	NO	YES
Insomnia	NO	YES

INTEGUMENTARY (skin and breast):

Rash or itching	NO	YES
Change in skin color	NO	YES
Change in hair or nails	NO	YES
Varicose veins	NO	YES
Breast pain	NO	YES
Breast lump	NO	YES
Breast discharge	NO	YES

NEUROLOGICAL:

Frequent or reoccurring headaches	NO	YES
Light-headed or dizziness	NO	YES
Convulsions or seizure	NO	YES
Numbness or tingling sensations	NO	YES
Tremors	NO	YES
Paralysis	NO	YES
Stroke	NO	YES
Head injury	NO	YES

ENDOCRINE:

Glandular or hormone problem	NO	YES
Thyroid disease	NO	YES
Diabetes	NO	YES
Excessive thirst or urination	NO	YES
Heat or cold intolerance	NO	YES
Skin becoming drier	NO	YES
Change in hat or glove size	NO	YES

HEMATOLOGIC/LYMPHATIC:

Slow to heal after cut	NO	YES
Bleeding or bruising	NO	YES
Anemia	NO	YES
Phlebitis	NO	YES
Past blood transfusion	NO	YES
Enlarged glands	NO	YES
Hepatitis A B C	NO	YES
Jaundice	NO	YES