New Patient Medical History

Patient Name _____ Today's Date _____

Date of Birth _____

Chief Complaint: _____

PATIENT MEDICAL HISTORY

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

Diabetes……	☐ No	☐ Yes	Heart Surgery……..	☐ No	☐ Yes
Hypertension……	☐ No	☐ Yes	Heart Attack…….	☐ No	☐ Yes
Breast Cancer……..	☐ No	☐ Yes	Angioplasty……	☐ No	☐ Yes
Colon Cancer……...	☐ No	☐ Yes	Pacemaker/AICD……..	☐ No	☐ Yes
Other Cancer……	☐ No	☐ Yes	Stent……	☐ No	☐ Yes
			Cardiac Arrest……...	☐ No	☐ Yes
Stroke……	☐ No	☐ Yes	Congestive Heart Failure……..	☐ No	☐ Yes
Arthritis……	☐ No	☐ Yes	Valvular disease……	☐ No	☐ Yes
Convulsions……..	☐ No	☐ Yes			
Bleeding tendency……	☐ No	☐ Yes	Tuberculosis……	☐ No	☐ Yes
Acute Infections……...	☐ No	☐ Yes	Asthma…….	☐ No	☐ Yes
Venereal disease……..	☐ No	☐ Yes	Emphysema…….	☐ 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			

PREVIOUS SURGERIES/HOSPITALIZATIONS	**DATES**
_____	_____
_____	_____
_____	_____
_____	_____

PATIENT SOCIAL HISTORY

Marital Status:	Single ☐	Married ☐	Separated ☐	Divorced ☐	Widowed ☐
Alcohol Use:	Never ☐	Rarely ☐	Moderate ☐	Daily ☐	
Tobacco Use:	Never ☐	Previously ☐	Type/frequency _____		
Drug use:	Never ☐	Previously ☐	Type/frequency _____		

FAMILY MEDICAL HISTORY

	Age	State of Health	Age at Death	Cause of Death
Father	_____	_____	_____	_____
Mother	_____	_____	_____	_____
Brothers	_____	_____	_____	_____
	_____	_____	_____	_____
Sisters	_____	_____	_____	_____
	_____	_____	_____	_____

_____ _____

Stephen P. Maniscalco MD Date
John W. Davis III, MD
Jack Lai PA-C

Charlie F. Dendy DO Date
Matthew Marcus McTague DO
J. Alan Przybyla, MD

7/2010sp

New Patient Medical History

Patient name_____ **Date of Birth**_____ **Todays 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 or 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 walking or lying flat	☐No	☐Yes
Swelling of feet, ankles, or hands……	☐No	☐Yes

RESPIRATORY

Chronic or frequent coughs……..	☐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

GENITOURINARY

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_____

PSYCHIATRIC

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 recurring 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

_____

Stephen Maniscalso MD **DATE**
John Davis MD
Jack Lai PA-C

_____

Charlie F. Dendy DO
Matthew Marcus McTague DO
J. Alan Przybyla, MD