

# 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
Stroke.....	No	Yes	Cardiac Arrest.....	No	Yes
Arthritis.....	No	Yes	Congestive Heart Failure.....	No	Yes
Convulsions.....	No	Yes	Valvular disease.....	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
<b>Father</b>	_____	_____	_____	_____
<b>Mother</b>	_____	_____	_____	_____
<b>Brothers</b>	_____	_____	_____	_____
	_____	_____	_____	_____
<b>Sisters</b>	_____	_____	_____	_____
	_____	_____	_____	_____

\_\_\_\_\_  
**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**

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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 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

\_\_\_\_\_  
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