# NEW PATIENT EVALUATION

DATE:

FULL NAME:

DATE OF BIRTH:

REASON FOR YOUR VISIT:

## PAST MEDICAL HISTORY

**Do you feel your general health is (check one):**

- ☐ Excellent
- ☐ Very Good
- ☐ Good
- ☐ Fair
- ☐ Poor

**Allergies (to what, what reaction):**

**Childhood Illnesses:**

**Adult Illnesses:**

**Surgeries:**

**Health Maintenance (Please provide the date and result of your last):**

- ☐ Physical Exam:
- ☐ Colonoscopy:
- ☐ Pap Smear:
- ☐ Mammogram:
- ☐ Labs:
- ☐ Eye Exam:
- ☐ Dental Exam:

## FAMILY HISTORY

**Please list any significant illnesses (or cause of death) you could inherit from:**

- ☐ Mother:
- ☐ Father:
- ☐ Maternal Grandmother:
- ☐ Maternal Grandfather:
- ☐ Paternal Grandmother:
- ☐ Paternal Grandfather:
- ☐ Siblings:
- ☐ Children:
- ☐ Other:

## SOCIAL HISTORY

Marital Status:

Children:

Occupation:

Activities:

Religious Affiliation:

Tobacco Use:

Alcohol:

Recreational Drugs:

Exercise:

Dietary Preferences:

Water Intake/Day:

Caffeine Intake/Day:

Are You Stressed?:

Is Money a Stressor?:

Wear Seatbelt: ☐ Yes ☐ No

Exposure to Toxic Chemicals: ☐ Yes ☐ No Type: When:

## REVIEW OF SYSTEMS – Do you have any of the following symptoms? Please provide additional information as appropriate.

**General:**

- ☐ Fever
- ☐ Chills
- ☐ Weight Gain
- ☐ Weight Loss
- ☐ Night Sweats
- ☐ Fatigue

**Skin:**

- ☐ Rash
- ☐ Wound
- ☐ Moles
- ☐ Other Abnormality

**HEENT:**

- ☐ History Head Injury
- ☐ Headaches
- ☐ Visual Disturbances
- ☐ Wear Glasses/Contacts
- ☐ Hearing Difficulties
- ☐ Tinnitus (Ringing in Ears)
- ☐ Vertigo
- ☐ Allergic Rhinitis (Allergies)
- ☐ Nosebleeds
- ☐ Dental Issues
- ☐ Swollen Glands
- ☐ Dysphagia (Trouble Swallowing)

**Respiratory:**

- ☐ Shortness of Breath with or without Exertion
- ☐ Cough
- ☐ Wheezing
- ☐ Blood in Sputum
- ☐ Asthma
- ☐ Snoring/Sleep Apnea

**Cardiovascular:**

- ☐ Chest Pain
- ☐ Palpitations
- ☐ Hypertension (High Blood Pressure)
- ☐ Hypotension (Low Blood Pressure)
- ☐ Hyperlipidemia (High Cholesterol)
- ☐ Edema
- ☐ Leg/Calf Pain or Cramping
- ☐ Varicose Veins

**Gastrointestinal:**

Bowl Movement Frequency (Please fill in):

- ☐ Decreased Appetite
- ☐ Increased Appetite
- ☐ Heartburn
- ☐ GERD (Reflux)
- ☐ Diarrhea
- ☐ Constipation
- ☐ Vomiting
- ☐ Nausea
- ☐ Abdominal Pain
- ☐ Abdominal Bloating
- ☐ Hemorrhoids
- ☐ Blood in Stool

**Urinary:**

- ☐ Urinary Frequency
- ☐ Urinary Hesitancy
- ☐ Urinary Incontinence
- ☐ Burning on Urination
- ☐ Hematuria
- ☐ Painful Urination

**Genital:**

- ☐ Last Menstrual Period (1st day) or Date of Menopause:
- ☐ Amenorrhea (No Period)
- ☐ Dysmenorrhea (Painful Periods)
- ☐ Menorrhagia (Heavy Periods)
- ☐ Vaginal Discharge
- ☐ Vaginal Lesion
- ☐ History Sexually Transmitted Infection (What Type and When?):
- ☐ Menopause
- ☐ Hot Flashes
- ☐ History of Abnormal Pap Smear
- ☐ Breast Lump, Pain, Discharge

**Musculoskeletal:**

- ☐ Myalgia (Muscle Aches, Where?):
- ☐ Arthralgia: (Joint Pain, Where?):
- ☐ Back Pain

**Neurologic:**

- ☐ History of Seizure
- ☐ Tremor
- ☐ Migraine
- ☐ Dizziness
- ☐ Vertigo
- ☐ Syncope (Lightheadedness, Fainting)
- ☐ Weakness
- ☐ Numbness/Tingling
- ☐ Neuropathy

**Hematologic:**

- ☐ Ease of Bleeding
- ☐ Ease of Bruising
- ☐ History Blood Transfusion

**Endocrine:**

- ☐ Hypothyroid
- ☐ Hyperthyroid
- ☐ Increased Appetite
- ☐ Decreased Appetite
- ☐ Heat Intolerance

- ☐ Cold Intolerance
- ☐ Excessive Sleepiness

**Psychiatric:**

- ☐ Depression
- ☐ Anxiety
- ☐ Insomnia: Trouble Falling Asleep
- ☐ Insomnia: Trouble Staying Asleep
- ☐ Thoughts of Harm to Self or Others
- ☐ Memory Disturbance

**Please provide additional information below on anything you checked above:**