NEW PATIENT - HISTORY

Identification Information

Patient Name ______________________________________ Occupation ______________ Today's Date _________

Age ____ Date of Birth ________ Ethnicity ____________ Birthplace _______________ Year to L.A. __________

Marriage status (please circle): Single Married Divorced Widowed Separated Partner

Level of education completed: Grade/High school College degree Graduate school

Referral Information

Referred by _______________________________________ Last exam date ________________________________

Reason for today's visit ____

What other physicians are treating you? ____

Medical History

Allergies (medication, food, or others): ____________________ What type of reactions? _______________________

Current and past medical problems (circle ones that apply):

Allergies/ hay fever
Anemia
Angina (chest pain)
Arthritis
Asthma
Bleeding Tendencies
Cataracts
Cancer / Type____________
Chronic fatigue
Constipation
Depression
Diabetes
Diarrhea
Dizziness
Fainting spells
Glaucoma
Gout

Frequent trouble sleeping
Headaches
Heart attack
Heartburn
Heart disease
Heart murmur
Hepatitis
High blood pressure
High cholesterol
Incontinent
Indigestion
Kidney stones/ infections
Liver problems
Nausea / vomiting
Night sweats
Numbness of arms or legs
Other Problem not listed above: _______________________________________

Pain in calves when walking
Phlebitis
Prostate problems
Rapid or irregular heartbeat
Rheumatic or scarlet fever
Seizures
Significant weight gain/ loss
Stomach Ulcers
Stroke
Palpitations
Shortness of breath at rest
Shortness of breath with activity
Swelling in ankles or feet
Tuberculosis
Urination problems
Varicose veins

Procedure:

Have you ever had any of the following procedures performed? (please circle)

Cardiac catheterization Y / N Echocardiogram Y / N Stress test or treadmill Y / N

Chest x-ray Y / N Holter Y / N

Surgeries in the past: ____________________

____

Injuries in the past: ____________________

____

Last Hospitalization: (date) _________(hospital name) __________________ (reason) ______________________

Current Medications:

(Including aspirin, vitamins, supplements, and herbs. Please include name of the medication, strength, and frequency. For example—Lasix 40 mg twice daily)

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____

List any medications that have been discontinued:

____

Immunization:

When is the last time you had a flu shot? ____________________

Have you ever had Pneumovax? Y / N If yes, when? ____________________

Family History

FAMILY	If Living: AGE	HEALTH	If Deceased: AGE (at death)	CAUSE	Has any blood relative ever had:
Paternal grandparents					Cancer No Yes
Maternal grandparents					Tuberculosis No Yes
Father					Diabetes No Yes
Mother					Heart trouble No Yes
Brother					High blood pressure No Yes
Sister					Stroke No Yes
Husband/Wife					Bleeding tendency No Yes
Son/Daughter					Gout or other arthritis No Yes

Social History & Lifestyle

Are you living with anyone? Y / N If yes, with whom? ____

Are you retired or disabled? Y /N If yes, for how many years _______ Prior occupation: _____________

Are you currently employed? Y / N If yes, specify occupation _______________________________________

Diet History:

Are you following a special diet? (please circle)

Low fat/Low cholesterol Low salt Low sugar

High fiber High protein Fluid restrictions Others: ______________________

What do you eat most of the time? ____

What is your favorite food? ____

How many times a week/month do you eat out? _______ per week / month (please circle)

Do you read food labels? Y / N

Exercise History:

Do you exercise? Y / N If yes, what type? ___________________ How often? _______________

What is your ideal body weight? _________ How much did you weigh when you were in your 20's? ____________

What is your maximum weight? _________ When? _________

Smoking History (including cigarettes, cigars and chewing tobacco):

Current smoker? Y / N If yes, how many packs per day? _____ For how many years? ____

Past smoker? Y / N If yes, how many packs per day? _____ For how many years? _____ Year quit: _____

Drinking History (including all alcoholic beverages, e.g. beer, wine, hard liquor and mixed drinks):

Current drinker? Y / N If yes, # of drinks per day/week/month/year? _____ # of years? ____

Past drinker? Y / N If yes, # of drinks per day/week/month/year? _____ # of years? ____ year quit: _____

History of drug use:

Have you ever used any illegal drugs? Y / N If yes, which kind? _________________________ Current / Past

Miscellaneous Confidential Information

Do you have any objections to our office leaving messages for you at home or work, as being calls from a Doctor's office? Y / N

If yes, please list the specific numbers we should not use, and indicate how we can leave a message.______________

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Revised Dec 30, 2007