

# NEW PATIENT HISTORY

Today's Date \_\_\_\_\_

Name: \_\_\_\_\_ Home#: \_\_\_\_\_ Work or Cell #: \_\_\_\_\_

SS#: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age \_\_\_\_ y.o. Sex: Male/Female Race: \_\_\_\_\_

Residing City: \_\_\_\_\_ Referring Doctor: \_\_\_\_\_

Chief Complaint: \_\_\_\_\_

## RECENT TESTING

Date/Place of test	Date/Place of test
EKG _____	Stress Test (type) _____
Chest X-ray _____	Monitor (24 or 30 day) _____
Echocardiogram _____	Cardiac Catheterization _____
Blood Work _____	Pacemaker/ICD (if so, when) _____

## PAST MEDICAL HISTORY

Chest Pain _____	Asthma _____	Diabetes _____
Palpitations _____	Bronchitis _____	Cancer _____
Shortness of Breath _____	Pneumonia _____	Seizures _____
Heart Murmur _____	Lung Disease _____	Kidney Disease _____
Heart Disease _____	High Cholesterol _____	Thyroid Disease _____
CHF _____	Ulcer _____	Peripheral Vascular Disease _____
Dizziness _____	GI Disorders _____	Claudication _____
Fainting _____	Reflux _____	Gallbladder Disease _____
Rheumatic Fever _____	Anemia _____	Prostate Disease _____
Edema (swelling) _____	Rectal Bleeding _____	Headaches _____
High Blood Pressure _____	Gout _____	Hepatitis (type) _____
Heart Valve Disease _____	Arthritis _____	Depression/Anxiety _____
Fast/Slow Heart Beat _____	Glaucoma _____	
	Cataracts _____	

## FAMILY HISTORY

Relation (Living/Deceased)	Age	Relation (Living/Deceased)	Age
Heart Disease _____		Diabetes _____	
High Blood Pressure _____		Cancer _____	
Stroke _____		Kidney Disease _____	

## SURGERIES/RECENT HOSPITALIZATIONS

Reason	Date	Hospital	Reason	Date	Hospital
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Over....

**NEW PATIENT HISTORY (CONTINUED)**

**CURRENT MEDICATIONS**

Please list name of medication, dose, frequency and how long you have been taking each medicine.

- 1. \_\_\_\_\_
- 2. \_\_\_\_\_
- 3. \_\_\_\_\_
- 4. \_\_\_\_\_
- 5. \_\_\_\_\_
- 6. \_\_\_\_\_
- 7. \_\_\_\_\_
- 8. \_\_\_\_\_
- 9. \_\_\_\_\_
- 10. \_\_\_\_\_
- 11. \_\_\_\_\_
- 12. \_\_\_\_\_

Allergies: \_\_\_\_\_

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**PATIENT LIFESTYLE**

Occupation: \_\_\_\_\_ Marital Status: S/M/W/D  
Smoke: amt: \_\_\_\_\_ PPD/how long \_\_\_\_\_ when quit: \_\_\_\_\_ Alcohol: type: \_\_\_\_\_ amt: \_\_\_\_\_  
Caffeine Use: Coffee (amount) \_\_\_\_\_ Tea (amount) \_\_\_\_\_ Soda (amount) \_\_\_\_\_  
Drug Use: \_\_\_\_\_ Special Diet: (type) \_\_\_\_\_ Regular Exercise: (type) \_\_\_\_\_

**(For office use only)**

**VITAL SIGNS**

Weight: \_\_\_\_\_(lbs)      Blood Pressure: \_\_\_\_\_      Heart Rate: \_\_\_\_\_

**REVIEW OF SYSTEMS:**

- Neurological \_\_\_\_\_
- Respiratory \_\_\_\_\_
- Cardiovascular \_\_\_\_\_
- GI/GU \_\_\_\_\_
- Skin \_\_\_\_\_
- Muscular/Skeletal \_\_\_\_\_