

NEW PATIENT ADULT FORM

- Please answer all of the following questions to the best of your ability.

Patient's Name: _____ DOB: _____

CHIEF COMPLAINT:

What is the reason for this appointment? _____

HISTORY OF PRESENT ILLNESS:

Where does it hurt or bother you? _____

What kind of pain? ___Sharp ___Dull ___Constant ___Intermittent

When did the problem start? _____

Does anything make it better or worse? _____

Any other associated symptoms? _____

PAST MEDICAL HISTORY:

List any medical conditions that you are/have been treated for (asthma, high blood pressure, diabetes, etc.)

List previous surgeries:

List all medicine you are taking: 1. _____ 2. _____ 3. _____

4. _____ 5. _____ 6. _____ 7. _____

List drug allergies: _____

SOCIAL HISTORY:

Your occupation? _____

Do you now or have you ever smoked or chewed tobacco? _____ How much? _____

Do you now or have you ever drank alcoholic beverages? _____ How much? _____

Do you have any of the following?

REVIEW OF SYSTEMS

NO **YES**

Anesthesia Complications	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Easy Bleeding / Bruising	<input type="checkbox"/>	<input type="checkbox"/>
Fevers	<input type="checkbox"/>	<input type="checkbox"/>
Hearing Loss	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>
Heartburn / Reflux	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>

REVIEW OF SYSTEMS

NO **YES**

Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>
Lung Disease	<input type="checkbox"/>	<input type="checkbox"/>
Migraines	<input type="checkbox"/>	<input type="checkbox"/>
Muscle Aches	<input type="checkbox"/>	<input type="checkbox"/>
Rash	<input type="checkbox"/>	<input type="checkbox"/>
Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Snoring	<input type="checkbox"/>	<input type="checkbox"/>
Stomach Problems	<input type="checkbox"/>	<input type="checkbox"/>
Unexplained Weight Loss	<input type="checkbox"/>	<input type="checkbox"/>
Visual	<input type="checkbox"/>	<input type="checkbox"/>
Wheezing	<input type="checkbox"/>	<input type="checkbox"/>
Other:	<input type="checkbox"/>	<input type="checkbox"/>

If "Yes" please describe _____

FAMILY HISTORY:

Do any of the diseases above run in your family? _____

Are there any bleeding disorders or "free bleeders" in your family? _____