NEW PATIENT

Name: ____________________________ Date: ______________

Do you have Medicare or Medicaid? YES / NO

Reason for todays visit: ______________________________ Referring doctor: ______________________

Description of how your problems started and progressed to date.

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Pain level is (circle) 1 2 3 4 5 6 7 8 9 10
Pain is described as (circle) sharp dull stabbing burning aching shooting throbbing
Worst time of is (circle) morning midday evening
Morning stiffness lasts (circle) < 30min 30-60min > 60min
Have you had? (circle) fluid around heart or lung, mouth sores, rash in the sun, low blood counts, blood or protein in the urine, seizures, numbness/tingling, fatigue, unexplained fever, hair loss, red eye(s), psoriasis, bloody diarrhea)

Allergies: (list all medications that you are allergic to and the reaction)

_____________________________________ _____________________________________

_____________________________________ _____________________________________

Medications: (list name of medication and dose/frequency)
____ ***Example: Lyrica 100mg twice a day*** ______________________ _____________________________________

_____________________________________ _____________________________________

_____________________________________ _____________________________________

_____________________________________ _____________________________________

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Personal Medical History (circle)

RA	Lupus	Gout	Sjogrens	PMR	Psoriatic arthritis
Ulcerative Colitis	Crohn’s	Psoriasis	Heart attack	Heart failure	Cancer
Aneurysm Clips	Back pain	Neck pain	Fibromyalgia	Osteoporosis	Diabetes
Sleep apnea	PTSD	Depression	Anxiety	Addiction	Thyroid disease
Pacemaker	Hepatitis	TB or +PPD	Multiple sclerosis	Stomach ulcer	Gastric bypass

Other: ____

Past Surgical History (list all surgeries)

___________________________________ ___________________________________
___________________________________ ___________________________________
___________________________________ ___________________________________

Family history (do you have a blood relative with any of the following?)

RA	Lupus	Gout	Fibromyalgia	Psoriasis	Psoriatic arthritis
Cancer	Heart disease	Addiction	Depression	Anxiety	Sjogrens
Osteoporosis	Multiple sclerosis	Thyroid disease	Diabetes	Crohn’s	Ulcerative colitis

Other: ____

Social History:
Do you smoke cigarettes? Yes / No
Do you drink alcohol? Yes / No If yes, how many drinks per week? _______
Do you use marijuana? Yes / No
Do you have history of drug or alcohol dependence? Yes / No
Do you exercise at least once a week? Yes / No
Is there any chance of becoming pregnant (or if male impregnating your partner)? Yes / No
Employment? _________________________
Are you applying for (or already on) disability? Yes / No

Review of systems: (circle symptoms present in past 2 weeks)

GENERAL
Recent weight gain; Recent weight loss; Fatigue; Weakness; Fever; Night sweats

NECK/THROAT
Frequent sore throats; Hoarseness; Difficulty in swallowing; Pain in jaw while chewing; Swollen glands; Tender glands

HEART AND LUNGS
Pain in chest; Irregular heart beat; Sudden changes in heart beat; Shortness of breath; Swollen legs or feet; Cough; Coughing of blood

STOMACH AND INTESTINES
Nausea; Heartburn; Stomach pain relieved by food; Vomiting of blood/”coffee grounds”; Yellow jaundice; Increasing constipation; Persistent diarrhea; Blood in stools; Black stools

MUSCLE/JOINTS/BONES
Morning stiffness lasting over an hour; Joint pain; Muscle weakness; Joint swelling

EARS
Ringing in ears; Loss of hearing; Red/Swollen ear

EYES
Redness; Loss of vision; Double or blurred vision; Dryness; Feels like something in eye

MOUTH
Sore tongue; Bleeding gums; Sores in mouth; Loss of taste; Dryness; Recent increase in tooth cavities

NOSE
Nosebleeds; Loss of smell

KIDNEY/URINE/BLADDER
Difficult urination; Pain or burning on urination; Blood in urine; Discharge from penis/vagina Vaginal dryness; Genital ulcers

SKIN
Tightness of skin; Rash on body, Facial rash, Color change of hands in cold, sun sensitivity, hair loss

NERVOUS SYSTEM
Headache, numbness/tingling of hands/feet

GYNECOLOGY
history of miscarriage

PSYCHIATRIC
Depression, Anxiety, Increased Stress, Suicidal Thoughts