New Patient Information

Name_____
Address_____
City/State/Zip_____
Phone_____
DL#_____
SSN#_____

Spouse_____
Nearest Relative_____

Your employer _____
Address _____
Spouse
Employer_____
Address _____
City/State/Zip

Referring Physician_____
Family Physician_____
Marriage Status Married / Divorced / Widowed
Single / Other
Age_____ Date of Birth_____
Sex: Male / Female

Spouse Work Phone_____
Relative Phone_____

Occupation_____

Work Phone_____

If Patient under 18 or lives with Parents

Father's Name_____
Father's Birthday_____
Father's SSN_____
Father's Employer_____
Employer Address_____
City/State/Zip_____
Work Phone_____

Mother's Name_____
Mother's Birthday_____
Mother's SSN_____
Mother's Employer_____
Employer Address_____
City/State/Zip_____
Work Phone_____

Health Insurance

How do you intend to pay for today's visit? Cash / Check / Visa / MasterCard

Name of Responsible Party_____
Was this and Accident? Yes / No
On the Job/ Yes / No
Date of Injury_____
Date of Previous Injury to same body part_____

Which applies to your? (circle):

Medicare
HMO #_____
PPO Private Pay

Primary Insurance

Insured by: Self / Spouse / Parent
Insurance Co._____
Address:_____
City/State/Zip_____
Insurance Type: Group / Individual
Group #_____
Policy#_____ Cert#_____
Insured SSN_____
Insured D.O.B._____
Medicare #_____

Secondary Insurance

Insured by: Self / Spouse / Parent
Insurance Co._____
Address:_____
City/State/Zip_____
Insurance Type: Group / Individual
Group #_____
Policy#_____ Cert#_____
Insured SSN_____
Insured D.O.B._____
Medicare #_____

Patient/Guardian Signature_____ Date:_____

Past Medical History

Primary care physician:_____ Date of last exam:_____

Please check if you have had any of the following:

- ☐ Childhood diseases
- ☐ Cancer
- ☐ Stomach Ulcer
- ☐ Seizures
- ☐ Irregular heartbeat
- ☐ HIV / AIDS
- ☐ Colitis
- ☐ Blood transfusions
- ☐ High blood pressure
- ☐ Psychiatric problems
- ☐ Thyroid disease
- ☐ Bleeding problems
- ☐ Heart problems
- ☐ Hepatitis
- ☐ Kidney disease / stones
- ☐ Blood clots
- ☐ Rheumatoid arthritis
- ☐ Asthma
- ☐ Diabetes
- ☐ Stroke
- ☐ High cholesterol
- ☐ Emphysema
- ☐ Broken bones
- ☐ Urinary infections
- ☐ Scoliosis
- ☐ Pneumonia
- ☐ Osteoporosis
- ☐ Leg length inequality
- ☐ Liver disease
- ☐ Gout
- ☐ Lupus
- ☐ Rheumatic fever
- ☐ Fibromyalgia

If other conditions, please list _____
_____

Women
Are you pregnant? (circle) Yes / No

Surgical History

Please list all surgeries with approximate year according to the categories listed:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Patient Name _____ Date: _____

Medication Record

Please list current: prescriptions, over-the-counter medications, and alternative remedies
Indicate if you cannot remember all of your medications: ☐
Always bring an updated medication list to all future appointments.

Medication Name	Dose	Route	How Often

Allergies:

Please indicate your medication allergies and the reaction to each medication.
If you have no known allergies, please write that down.

Medication	Reaction Type

Social History

Please circle or fill in the blank:

Sex: Male / Female Height: ____ft _____in Weight: _____ lbs

Marital Status: Married / Single / Divorced / Widowed

Children: Yes / No How many? _____

Have you ever required a blood transfusion? Yes / No Date _____ Number of units _____

Have you ever smoked? Yes / No

Do you drink alcohol? Yes / No How many drinks per week? _____

Have you ever had problems with drug / alcohol use? Yes / No

Job description:_____

Patient Name _____ Date: _____

Review of Systems

Please Circle Symptoms

General: recent weight changes, fever, weakness, fatigue, headaches
☐ No problem

Skin: rashes, eruptions, dryness, jaundice, changes in skin/hair/nails, discoloration, swelling
☐ No problem

Eyes: blurred vision, double vision, burning eyes
☐ No problem

Ears/Nose/Throat: hoarseness, difficulty swallowing, Head colds, nasal drainage, obstruction, Sinus pain, ear ache, hearing loss, hearing aids
☐ No problem

Musculoskeletal: joint pain, swelling, stiffness, deformity
☐ No problem

Pulmonary: difficulty breathing, asthma, bronchitis, Pneumonia, shortness of breath
☐ No problem

Neurological: fainting, paralysis, dizzy spells, numbness
☐ No problem

Cardiovascular: chest pain, rheumatic fever, rapid heartbeat, Leg swelling, heart valve problems, varicose veins, heart attack
☐ No problem

Endocrine: fatigue, hot or cold intolerance, excessive sweating, Thirst, hunger
☐ No problem

Gastrointestinal: decrease in appetite, nausea, vomiting, Diarrhea, constipation, heartburn, hemorrhoids, reflux, blood in Stool, ulcers
☐ No problem

Genitourinary: change in urinary frequency, urinary pain, blood In urine, difficulty voiding, incontinence
☐ No problem

Hematological/Lymphatic: anemia, easy bruising or bleeding, Swollen glands
☐ No problem

Psychological: nervousness, mood swings, insomnia, Depression,
☐ No problem

Other:_____

_____

_____

Family History

Please check if any of the following occur in your family:

- ☐ Cancer
- ☐ Seizures
- ☐ High blood pressure
- ☐ Thyroid disease
- ☐ Bleeding problems
- ☐ Heart problems
- ☐ Kidney problems / stones
- ☐ Blood clots
- ☐ Arthritis
- ☐ Problems with general anesthesia
- ☐ Diabetes
- ☐ Stroke
- ☐ High cholesterol
- ☐ Broken bones
- ☐ Scoliosis
- ☐ Lung problems
- ☐ Osteoporosis
- ☐ Liver disease
- ☐ Gout
- ☐ Lupus

If other conditions occur in your relatives, please list _____

_____

_____

Physician Verification: _____ Date: _____

Patient Name _____ Date: _____