NEW PATIENT INFORMATION FORM (Complete Yearly)

| Date | Other Physicians: | | | |
|--|-------------------|-------------|--|--|
| Name: | | | | |
| Referred by: | | | | |
| Primary Care Physician: | | | | |
| Spouse's Name: Who lives with you? | | | | |
| Employment: | Date of Birth | Age | | |
| Employment. | Right Handed | Left Handed | | |
| | | | | |
| Reason for Visit: | | | | |
| | | | | |
| Past Surgical History (Circle | <u> </u> | | | |
| | | | | |
| Brain: Aneurysm Tumor Subdural Hematoma | Date | | | |
| Other: | | | | |
| Spine: Cervical Thoracic Lumbar Laminectomy Fusion Tumor | Date | | | |
| Other: | | | | |
| ENT: Tonsillectomy Adenoidectomy Sinus Ear Thyroid | Date | | | |
| Other: | | | | |
| General: Appendix Hernia Bowel Gallbladder Bypass/Banding | Date | | | |
| Other: | | | | |
| Orthopedic: Shoulder Hip Knee | Date | | | |
| Other: | | | | |
| Heart: Pacemaker AICD (Implantable Defibrillator) Bypass Valve | Stent Date | | | |
| Other: | | | | |
| Other: | | | | |
| GYN: Hysterectomy Mastectomy Lumpectomy Biopsy | | | | |
| Other: | <u></u> | | | |
| Urologic: Bladder Kidney Prostate TURP | | | | |
| Other: | | | | |
| Cosmetic: Face Breast Abdomen | | | | |
| Other: | | | | |
| | | | | |

| Past Medical History other than Surgery (Circle) | | | | |
|---|--|--|--|--|
| Neurologic: Headache Migraine Aneurysm Trauma Dementia Parkinson's Stroke Other: | | | | |
| Cancer: Brain Lung Breast Colon Gyn Prostate Melanoma Skin Lymphoma Leukemia | | | | |
| Other: | | | | |
| Musculoskeletal: Rheum Arthritis Osteoarthritis Fibromyalgia Lupus Sjogren's Osteoporosis | | | | |
| Other: | | | | |
| Skin: Eczema Neurofibromatosis Psoriasis | | | | |
| Other: | | | | |
| Eyes: Cataracts Glaucoma Macular Degeneration Retina Legally Blind | | | | |
| Other: | | | | |
| Ears: Deafness Ringing Vertigo | | | | |
| Other: | | | | |
| Respiratory: Asthma Bronchitis Emphysema COPD Pneumonia | | | | |
| Other: | | | | |
| Cardiac: Angina Atrial Fibrillation Irregular Beat Heart Attack Coronary Disease Valve Disease Hypertension | | | | |
| Other: | | | | |
| Vascular: Peripheral Vascular Disease Aortic Aneurysm DVT/Blood Clots Pulmonary Embolus | | | | |
| Other: | | | | |

| SPECIALISTS | | | | |
|---|---|--|--|--|
| Gastrointestinal: Ulcer Reflux (GERD) Diverticulitis Colitis Cirrhosis Hepatitis Pancreatitis | 7 | | | |
| Other: | | | | |
| Urinary: Kidney Failure Stones Urinary Tract Infections Enlarged Prostate | | | | |
| Other: | | | | |
| Hematologic: Anemia Easy Bleeding Easy Bruising Low Platelets Other: | | | | |
| Endocrine: Pituitary Diabetes Low Thyroid High Thyroid | | | | |
| Other: | | | | |
| Infectious Disease: HIV/AIDS Lyme Disease Tuberculosis | | | | |
| Other: | | | | |
| Psychiatric: Anxiety Disorder Depression Bipolar Disorder | | | | |
| Other: | | | | |
| Neck, Back and Spine: | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| Use of Alcohol: Never Rarely Moderate Heavy Amount per Day: | | | | |
| Use of Tobacco: Never Previous Current Packs per day: Date Quit: | | | | |
| Marital Status: | | | | |
| | | | | |
| Family History Living Deceased (age) Illnesses | | | | |
| Mother | | | | |
| Father | | | | |
| Sisters (#) | | | | |
| Brothers (#) | | | | |
| Children (#) | | | | |

Allergies (and reaction):

Medications (prescription and non-prescription/OTC): Please list dose and schedule (times per day)

| Please list dose and schedule (times per day) | | | | |
|---|--|--|---------------------------------------|--|
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| 14. | | | · · · · · · · · · · · · · · · · · · · | |

Pharmacy Info: _____

Draw Areas of Pain (if applicable):

