New Patient Information Form

Date _____

Name _____ Home Phone_____

Address _____ Cell Phone_____

City _____ State _____ Zip _____ Work Phone _____

Occupation _____ Email _____

DOB _____ Age _____ Height _____ Weight _____ Sex: ☐ Female ☐ Male ☐ Transgender

Marital Status : ☐ Married ☐ Domestic Partner ☐ Divorced ☐ Widowed ☐ Separated ☐ Single

How did you learn about our clinic? _____

In case of emergency notify _____ Relationship_____

Their home phone _____ Work phone _____ Cell phone _____

Physician _____ Physician's phone_____

Physician Address _____
Street City State Zip code

The reason for your visit? _____

_____

How long have you had this condition?_____ Have you had it in the past? _____

_____

If yes, (in the past) describe when_____

What makes it better? _____

What makes is worse? _____

Is your condition... : getting worse_____ getting better_____ constant _____ comes and goes _____

If applicable, circle a number to indicate your level of pain. Minimal = 1 2 3 4 5 6 7 8 9 10 = extreme

If you have been given a diagnosis, what is it?_____

Diagnosing physician_____ Are any other doctors treating this condition? Y / N

Are you under the care of another physician for any other problems? (list problem and physician)_____

_____

_____

What kinds of treatments have you tried? _____

List all medications, hormones, laxatives, herbs, homeopathics, and supplements you are taking and for what reason:

_____

_____

_____

_____

Medical History

Date of your last physical exam_____ By whom? _____

List surgeries and dates _____

_____

_____

Significant accidents and traumas with dates _____

_____

_____

Do you:

☐ Smoke How much and how often: _____

☐ Drink alcohol How much and how often:_____

☐ Take recreational drugs How much and how often: _____

Do you have or have ever had:

☐ AIDS, or HIV	☐ Arthritis	☐ Tuberculosis	☐ Dyslexia
☐ Heart trouble	☐ Cancer	☐ Sexually transmitted disease	☐ Kidney or bladder trouble
☐ Hepatitis	☐ Epilepsy	☐ Thyroid problems	☐ Scarlet fever
☐ Gallstones	☐ Hemophilia	☐ Ulcers	☐ Sudden weight loss
☐ Rheumatic fever			

Have you ever taken adrenal corticosteroids (cortisone, prednisone, etc)? How long? _____

Have you had more than 2 courses of antibiotics in your lifetime? Y / N How many? _____

Do you have silver amalgam fillings? _____

Unusual birth history (prolonged labor, forceps delivery, C-section, etc)? _____

Please list scars from accident/surgery: _____

What inoculations have you had?

☐ Tetanus (lockjaw)	☐ Smallpox	☐ Diphtheria	☐ Poliomyelitis	
☐ Pertussis (whooping cough)	☐ Rubella (German measles)	☐ Measles	☐ Flu	☐ Other _____

What inoculations have you had in the last year? _____

Where have you traveled outside this country? _____

Family Medical History

Has anyone in your family had any of the following disorders?

☐ Alcoholism	☐ Asthma	☐ Diabetes	☐ High blood pressure	☐ Lung disease
☐ Allergies	☐ Cancer	☐ Epilepsy	☐ Kidney disease	☐ Mental Disorder
☐ Arthritis	☐ Coronary artery disease	☐ Heart disease	☐ Liver disease	☐ Stroke

Symtoms (Do you suffer from any of the symtoms below)

General

☐ Head or chest cold	☐ Night sweats	☐ Anemia	☐ Recent weight loss	☐ Flu
☐ Perspire easily w/o exertion	☐ Always fatigued	☐ Recent weight gain	☐ Recurrent fever	☐ Rarely perspire
☐ Fatigued easily	☐ Often thirsty	☐ Sudden drop in energy	☐ Chills	☐ Jaundice
☐ Seldom thirsty				

Head, Ears, Nose, Mouth and Throat

☐ Frequent colds	☐ Dizziness or loss of balance	☐ Deafness	☐ Sores on tongue
☐ Sinus congestion or pain	☐ Concussion	☐ Nasal congestion	☐ Sores in mouth (canker)
☐ Facial pain	☐ Seizures	☐ Runny nose	☐ Sores on lips (fever blister)
☐ Jaw tension or clicking (TMJ)	☐ Headache	☐ Nose bleeds	☐ Difficulty swallowing
☐ Grinding teeth	☐ Migraine Headache	☐ Sneezing	☐ Lump or pit in throat
☐ Frequent dental cavities	☐ Congestion in ears	☐ Allergies	☐ Sore throat
☐ Gum problems	☐ Earache	☐ Decreased sense of smell	☐ Strep throat
☐ Bleeding gums	☐ Ringing in ears	☐ Dry mouth	☐ Swollen lymph nodes
☐ Dentures	☐ Difficulty hearing	☐ Excessive saliva or drooling	☐ Tonsillitis

Eyes

☐ Nearsighted (myopia)	☐ Night blindness	☐ Eye pain	☐ Conjunctivitis
☐ Farsighted (hyperopia)	☐ Sensitivity to light	☐ Dry eyes	☐ Use eyeglasses or contacts
☐ Astigmatism	☐ Blurred vision	☐ Watery eyes	☐ Blindness
☐ Glaucoma	☐ Floating Spots	☐ Itchy eyes	
☐ Cataracts	☐ Pressure behind eyes	☐ Red eyes	

Respiratory

☐ Chronic cough	☐ Thin, watery phlegm	☐ Pneumonia	☐ Asthma: more difficult exhale
☐ Dry cough	☐ Clear or white phlegm	☐ Pain with deep breath	☐ Asthma: more difficult inhale
☐ Tight , rattling cough	☐ Yellowish phlegm	☐ Shortness of breath	☐ Asthma: worse on exhale
☐ Loose cough	☐ Blood in phlegm	☐ Emphysema	
☐ Thick, sticky phlegm	☐ Bronchitis	☐ Wheezing	

Cardiovascular

- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Blackouts or fainting
- ☐ Irregular heartbeat
- ☐ Heart valve problem/murmur
- ☐ Rapid heartbeat/palpitations
- ☐ Angina or chest pain
- ☐ Coronary heart disease
- ☐ High cholesterol
- ☐ Stroke
- ☐ Blood clot
- ☐ Phlebitis
- ☐ Varicose veins
- ☐ Bruise easily
- ☐ Anemia
- ☐ Edema
- ☐ Swelling of hands
- ☐ Swelling of feet
- ☐ Cold hands
- ☐ Cold feet
- ☐ Hot hands or palms
- ☐ Hot feet or soles
- ☐ Generally too hot
- ☐ Generally too cold

Gastrointestinal

- ☐ Constipation
- ☐ Hard stools
- ☐ Hemorrhoids
- ☐ Frequent laxative use
- ☐ Diverticulitis
- ☐ Parasites
- ☐ Abdominal bloating
- ☐ Foul smelling stools
- ☐ Undigested food in stool
- ☐ Black stool
- ☐ Belching
- ☐ Stomach acidity
- ☐ Indigestion
- ☐ Gurgling noise in stomach
- ☐ Bad breath
- ☐ Excessive appetite
- ☐ Blood in stool
- ☐ Lower abdominal pain/ cramping
- ☐ Upper abdominal pain/cramping
- ☐ Ulcer
- ☐ Nausea
- ☐ Erratic bowel movements
- ☐ Poor appetite
- ☐ Bowel movements feel incomplete
- ☐ Hiatal hernia
- ☐ Vomiting
- ☐ Colitis
- ☐ Diarrhea
- ☐ Loose stools
- ☐ Mucous in stool
- ☐ Gas (flatulence)

How often do you have a bowel movement? _____

Urinary and Genital

- ☐ Scanty or small amount of urine
- ☐ Flow does not stop quickly
- ☐ Excessive sexual energy
- ☐ Profuse or large amount of urine
- ☐ Pain or burning when urinating
- ☐ Blood in urine
- ☐ Ejaculation during sleep
- ☐ Kidney stones
- ☐ Decreased flow of urine
- ☐ Pain during intercourse
- ☐ Low sexual energy
- ☐ Inability to achieve orgasm
- ☐ Pain in bladder area
- ☐ Urgency to urinate
- ☐ Frequent urination
- ☐ Inability to maintain erection
- ☐ Sores on genitals
- ☐ Strong smelling urine
- ☐ Cloudy urine
- ☐ Low sperm count
- ☐ Prostate problems
- ☐ Bladder infection
- ☐ Kidney infection
- ☐ Dark urine
- ☐ Dribbling
- ☐ Bed wetting
- ☐ Clear urine
- ☐ Unable to hold urine
- ☐ Premature ejaculation
- ☐ Difficulty urinating

How often do you urinate in 24 hours? _____ How often do you wake to urinate at night?_____

Pregnancy and Gynecology

- ☐ Number of pregnancies _____
- ☐ Number of births _____
- ☐ Premature births_____
- ☐ Miscarriages _____
- ☐ Abortions_____
- ☐ Difficult deliveries
- ☐ Caesarean sections
- ☐ Age of children
- ☐ Age at first menses
- ☐ Date of last menses:__/__/___
- ☐ Duration of flow
- ☐ Clots
- ☐ Dark purple
- ☐ Dark brown
- ☐ Red
- ☐ Light colored/pale blood
- ☐ Painful periods
- ☐ Endometriosis
- ☐ Cramping before period starts
- ☐ Cramping after period starts
- ☐ Low backache with period
- ☐ Spotting between periods
- ☐ Vaginal discharge:strong odor
- ☐ Vaginal discharge brownish
- ☐ Vaginal discharge:white/curd-like
- ☐ Vaginal discharge:frothy & profuse
- ☐ Vaginal discharge:itchy
- ☐ Vaginal discharge:burning
- ☐ Abnormal pap
- ☐ Uterine fibroids
- ☐ Ovarian cysts
- ☐ Breast cysts or lumps
- ☐ Pelvic inflammatory disease

Pregnancy and Gynecology (Continued)

- ☐ Length of cycle
- ☐ Age at start of menopause
- ☐ Age menses stopped
- ☐ Hysterectomy
  Reason for_____
- ☐ Oophorectomy
  Reason for_____
- ☐ Have not yet begun menstruating
- ☐ Irregular cycle
- ☐ Heavy flow
- ☐ Light flow
- ☐ Missed periods
- ☐ Premenstrual irritability
- ☐ Premenstrual emotional sensitivity
- ☐ Premenstrual breast tenderness
- ☐ Premenstrual bloating
- ☐ Premenstrual fluid retention
- ☐ Premenstrual headache
- ☐ Premenstrual constipation
- ☐ Premenstrual diarrhea
- ☐ Hot flashes
- ☐ Vaginal discharge: no odor
- ☐ Currently have an IUD
- ☐ Previously had an IUD
- ☐ Current use of birth control pills
- ☐ Previous use of birth control pill
- ☐ Other birth control_____
- ☐ Cannot maintain pregnancy
- ☐ Trying to become pregnant
- ☐ Infertility
- ☐ Pregnant
- ☐ Nursing
- ☐ Nausea or morning sickness

Any other pregnancy or gynecological problems?_____ Date of last pap test_____

Musculoskeletal

- ☐ Neck pain/stiffness
- ☐ Low back pain/stiffness
- ☐ Weak ankles
- ☐ Elbow pain/stiffness
- ☐ Pain into calf or lower leg
- ☐ Muscle weakness
- ☐ Upper back pain/stiffness
- ☐ Mid back pain/stiffness
- ☐ Ankle pain/stiffness
- ☐ Upper arm pain/stiffness
- ☐ Pain into thigh or upper leg
- ☐ Muscle spasms
- ☐ Numbness or tingling in hands
- ☐ Weak knees
- ☐ Leg or calf cramping
- ☐ Shoulder joint pain/stiffness
- ☐ Hip joint pain/stiffness
- ☐ Numbness or tingling in feet
- ☐ Hand or finger pain/stiffness
- ☐ Knee pain/stiffness
- ☐ Stiff all over
- ☐ Shoulderblade pain
- ☐ Sacroiliac pain/stiffness
- ☐ Foot or toe pain/stiffness
- ☐ Wrist pain/stiffness
- ☐ Weak legs
- ☐ Paralysis

Is the problem helped by: _____ pressure _____heat _____cold _____other_____

Is the problem aggravated by: _____ pressure _____heat _____cold _____other_____

Skin and Hair

- ☐ Rashes
- ☐ Hives
- ☐ Itching
- ☐ Eczema
- ☐ Psoriasis
- ☐ Herpes Zoster (shingles)
- ☐ Boils
- ☐ Pimples or acne
- ☐ Ulcerations or sores
- ☐ Recent moles
- ☐ Recent change in mole
- ☐ Warts
- ☐ Dry Skin
- ☐ Moist feet
- ☐ Moist palms
- ☐ Fungus on skin
- ☐ Fungus under nails
- ☐ Weak or brittle nails
- ☐ Loss of hair
- ☐ Dandruff

Any numb areas? ☐ Yes ☐ No Where?_____

Sleep

- ☐ Difficulty falling asleep, wired
- ☐ Snoring
- ☐ Sleep too little
- ☐ Wake at night-mind empty, eyes open
- ☐ Nightmares
- ☐ Sleep too much
- ☐ Wake at night–thinking
- ☐ Sleepy in afternoon
- ☐ Needs to take naps
- ☐ Dream disturbed sleep
- ☐ Wake up unrefreshed
- ☐ Sleep with an electric blanket
- ☐ Shallow sleep
- ☐ Difficulty waking in a.m.
- ☐ Sleep on a waterbed

How many hours do you sleep in a 24 hour period?_____

Emotional

☐ Depression	☐ Mood swings	☐ Frequent crying	☐ Suicidal feelings
☐ Manic episodes	☐ Anxiety or fear	☐ Frequent anger or irritation	☐ Obsessiveness or compulsiveness
☐ Indecisiveness	☐ Sadness or grief	☐ Difficulty handling stress	☐ Tendency to repress emotions

Have you ever been emotionally, physically or sexually abused? _____

Have you ever been treated for emotional problems? _____

Have you had any recent stressful experiences (divorce, death of a loved one, bankruptcy, loss of a job, illness, injury, etc.)?

_____

Is there a constant stress in your life, at work, with your family, etc.? _____

Any other emotional problems?_____

_____

_____

_____

_____

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_____

The information on pages 1 - 3 is true to the best of my knowledge.

I understand and accept that I am responsible for full payment of my account and that payment is expected at the time of service.

I also understand and accept that I am expected to notify WIOGS 24 hours prior to any cancellations or changes to my appointment times and that if I do not I may be charged for the appointment.

Signed: _____

Date: _____

Parent / Guardian (if applicable) _____