New Patient Comprehensive History Form

Fox and Brantley Internal Medicine
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Confidential Record: Information contained here will not be released except when you have authorized us to do so.

Demographic Information

Last Name_____ First_____ Middle_____

DOB_____/_____/_____ Email _____

Street address_____

City _____ State _____ Zip code_____

Home Phone _____ Work Phone _____ Cell Phone _____

Emergency Contact: Name_____

Relationship to you_____

Home Phone_____ Work Phone_____

May we discuss routine lab results with someone else in your home if you are not there?

Y/N If so, whom?_____

Prior physician or referring physician_____

Date of last office visit there_____

How did you hear about our practice?_____

What is the reason for today's visit?_____

Please list the issues you want to discuss with your doctor.

_____

_____

Personal Information

Birth place_____ Education level_____

Occupation_____ Marital or relationship status_____

Describe religious or spiritual support_____

Do you have an advanced directive or living will? _____

Do you have a Health Care Power of Attorney? Y/N If so, who have you designated?

Name _____

Contact information _____

Past Medical, Surgical, and Psychological History

Please describe or list medical illnesses that you have or for which you have been treated:

List any operations you have had:

Describe any psychological (mental health) conditions for which you have received treatment or assistance (e.g.: medications, counseling, hospitalizations):

List date and reason for all prior hospitalizations:

Describe serious injuries or accidents that you have had:

Medications: List current medications and dosage, including over-the-counter medications and supplements:

Medication	Dose	Frequency

Do you have any medication or food allergies? **Y / N** If Yes, please list and describe the reaction_____

For Women:

Date of last Pap smear _____/_____/_____ Result: Normal ____ Abnormal____

If you have ever had an abnormal result, please describe: _____

_____

Date of last mammogram_____/_____/_____ Result: Normal____ Abnormal____

If you have ever had an abnormal result, please describe:_____

_____

For Men:

Have you discussed prostate cancer screening with a doctor? **Y/ N**

Have you had a prostate blood test (PSA) in the past? **Y/ N**

If you have ever had abnormal result, please describe: _____

_____

For Men and Women:

Have you had a colonoscopy for colon cancer screening? **Y/ N** If yes, date: _____

Results_____

What is your cholesterol level? Total_____ LDL_____ HDL_____ unknown_____

Have you had x-ray or radiation treatments, other than for treating cancer? **Y/ N**

Have you ever had high blood pressure? **Y/ N** If yes, describe: _____

Immunizations:
Please list the date(s) of your immunizations

Tetanus:	Pneumovax:	Zostavax:
Hepatitis A:	Hepatitis B:	Other:

Family Health History:

Because some names may be used for either men or women, please indicate the sex of each brother, sister, son, or daughter

Family Member	If Living			If Deceased	
	Sex	Age	Health	Age of death	Cause of death
Father	**M/F**				
Mother	**M/F**				
Brothers/Sisters	**M/F**				
	M/F				
	M/F				
Husband/Wife					
Sons/Daughters	**M/F**				
	M/F				
	M/F				

Please list any relative (parent or sibling) who has or had the following illnesses:

Cancer: Breast_____ Prostate_____ Other_____

Colon_____ age(s) _____ Colon Polyp_____ Type _____ (if known)

Vascular: High Blood Pressure_____ High Cholesterol_____

Stroke_____ Other_____

Early Heart Attack: Any heart attacks or bypass/stent surgery younger than age 65?

Y / N Who?_____

Mental Health:

Depression_____ Alcoholism_____

Drug addictions_____ Suicide_____ Other_____

Hormonal: Diabetes_____ Thyroid_____

Osteoporosis_____ Other_____

Other: TB_____ Bleeding tendency_____

Personal Health Habits:

Do you wear seat belts regularly? **Y / N**

Do you exercise regularly (three times a week) **Y / N** Describe _____

_____

Do you follow a particular nutritional plan? **Y / N**

Low fat___ Low salt___ High fiber___ Vegetarian ___ Diabetic diet___ Other ___

How stressful is your life? (circle the number that indicates your stress level)

1 2 3 4 5 6 7 8 9 10
(not stressful) (very stressful)

List the stressors: _____

_____

Do you cope with stress? **Y / N** How? _____

_____

Do you currently smoke regularly? **Y/ N**

Cigarettes_____ Pipe_____ Cigars_____ How many packs daily?_____

How many years have you smoked tobacco? _____

If you quit tobacco, what year did you quit? _____

For how many years did you smoke? _____How many packs daily?_____

Do you chew tobacco? **Y/ N** How much? _____

Do you drink sodas regularly? **Y / N** If yes, how many daily? _____

Do you drink alcohol **Y / N** If yes please describe what you drink and how much?_____

_____

Do you ever feel like you need to cut down on your alcohol? **Y / N**

Do you ever feel angry or upset when other people talk to you about drinking? **Y / N**

Do you ever drink alcohol in the morning? **Y / N**

Do you feel guilty about your drinking? **Y / N**

Do you feel sad often? **Y / N**

Have you noticed that you have lost interest in things you enjoyed in the past? **Y / N**

Please describe_____

Review of Systems:

Please circle the symptoms that you have regularly or that have been present in the last month:

GENERAL	HEENT	ENDOCRINE	CARDIOPULMONARY
Headaches Skin Rash Skin Sores Fatigue Fever Loss of appetite	Vision Decreased hearing Ringing in ears Dizziness Problems with teeth Sinus problems Hoarseness	Thyroid problems High blood sugar Increased thirst Increased urination	Chest pain Shortness of breath Palpitations Fainting spells Leg swelling Wheezing Cough
GASTROINTESTINAL	**URINARY**	**MUSCULOSKELETAL**	**NEUROLOGICAL**
Loss of appetite Abdominal pain Nausea or vomiting Constipation Diarrhea Hemorrhoids Blood in stools Problems swallowing	Painful urination Blood in urine Kidney stones Problems urinating Leakage of urine Frequent urination Urgent urination Sexual dysfunction	Arthritis Pain in joints Back pain	Seizures Tremors of shakes Numbness in hands Numbness in feet Weakness Stroke Memory problems