NEW PATIENT HISTORY

In order to treat you safely and effectively, please answer the following questions. This is for our records only, and responses are confidential.

Name: _____ Age: _____ Height: _____ Weight: _____

What is the reason for your visit? _____

_____

How long has this been present? _____

Allergies to medication? No Yes (please specify) _____

Medications (please include non-prescription meds and birth control pills; write "no" if none):

_____

_____

_____

Do you use aspirin or blood thinners daily? Yes No

If you are female, are you pregnant? Yes No Breastfeeding? Yes No

Past Medical History/Family History

	Yourself	Blood relative
Lupus, rheumatiod arthritis, other joint disease	_____	_____
Cancer	_____	_____
Diabetes	_____	_____
Eczema	_____	_____
Hayfever, allergies, hives	_____	_____
Hepatitis - Type?	_____	_____
Dysplastic nevi (abnormal moles)	_____	_____
Malignant melanoma	_____	_____
Psoriasis	_____	_____
Skin cancer (basal cell or squamous cell)	_____	_____
Thyroid disease	_____	_____
HIV/AIDS	_____	_____

Review of Systems

Transplantation	_____
Heart Disease	_____
Heart murmurs or MVP	_____
Artificial valve/Pacemaker	_____
High blood pressure	_____
Bleeding disorder	_____
Blood transfusions	_____
Joint aches	_____
Artificial joint	_____
Psychiatric disorder	_____
Bowel disease (Crohn's/colitis)	_____
Fever	_____

List other medical problems:

_____

Prior surgeries:

_____

Social history: Marital Status: _____ Occupation: _____

Do you smoke? No Yes (packs/day:____) Do you drink alcohol? No Yes (quantity:_____)

Patient Signature X_____ Date_____

Reviewed By:_____ Date_____

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