

# New Patient History Form

Name \_\_\_\_\_

Date \_\_\_\_\_

Primary Physician \_\_\_\_\_

Birth Date \_\_\_\_\_

**Chief Concern / Complaint:** \_\_\_\_\_

**Current Medications:** Please list all medications you are on, including vitamins, herbal supplements and contraception.

Medicine	Dosage / Times per day	Medicine	Dosage / Times per day
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**Allergies:** Please list all medicines AND the "allergic reaction" as well as the approximate date or age.

Medicine	Reaction	Approximate date / age
_____	_____	_____
_____	_____	_____
_____	_____	_____

**Operations:** Please list all surgeries and the approximate year it was done or age, such as, "Appendectomy, age 10"

_____	_____
_____	_____
_____	_____

**Past Medical History:** Please list all major illnesses you have had and the date or age at diagnosis

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

**Other Physicians:** Please list any other physicians involved in your care and their specialties

Prior PCP _____	_____
_____	_____
_____	_____

**Social History:**

Marital Status: (Circle one) M S D W How many years married (divorced or widowed) \_\_\_\_\_

Children: \_\_\_\_\_  
(please list name, age, and any major illnesses)

Occupation: \_\_\_\_\_ Educational Level: \_\_\_\_\_

Years in Arizona: \_\_\_\_\_ Born and Raised: City \_\_\_\_\_ State: \_\_\_\_\_

Do you smoke? (Circle one) Yes / Never / Quit Packs per day: \_\_\_\_\_ How many years? \_\_\_\_\_ Quit date: \_\_\_\_\_

Other tobacco? (Circle any) Pipe / Cigars / Chew Number of times per day \_\_\_\_\_ Quit date: \_\_\_\_\_

Alcohol Use: On average, how many drinks per day? \_\_\_\_\_, per month? \_\_\_\_\_ Type: Beer / Wine / Liquor

Do you have a living will or advanced directive? Yes / No

**Family Medical History:** Only applies to genetically related relatives. List those with the condition and age at onset.

Cancer (type if known): \_\_\_\_\_ Arthritis \_\_\_\_\_  
Heart Attack: \_\_\_\_\_ Asthma: \_\_\_\_\_  
High Blood Pressure: \_\_\_\_\_ Depression: \_\_\_\_\_  
Stroke: \_\_\_\_\_ Seizures: \_\_\_\_\_  
Diabetes: \_\_\_\_\_ Other: \_\_\_\_\_

**Review of Systems:** Please circle those symptoms you have frequently or apply to you.

**General:** Weight gain / loss Number or pounds \_\_\_\_\_ over the past \_\_\_\_\_ months or \_\_\_\_\_ years.

**Head:** Headache  
Dizziness  
Injury

**Cardiac:** Chest pain  
Palpitations  
Rheumatic Fever  
Short of breath  
with activity

**Urinary:** Frequent urination  
Burning with urination  
Blood  
Dribbling  
Leaking  
Slow stream

**Eyes:** Blurred vision  
Pain  
Spots or Lines

**GI:** Heartburn  
Trouble swallowing  
Loss of appetite  
Nausea  
Bloody or black stool  
Constipation  
Diarrhea  
Cramping  
Hemorrhoids

**Genital:** History of herpes  
Other STD's  
Decrease sex drive  
Decrease sexual performance

**ENT:** Hearing Loss  
Ringing  
Nasal congestion  
Nosebleeds  
Post nasal drip

**Women:** Last menstrual period: \_\_\_\_\_  
Number of pregnancies: \_\_\_\_\_  
Number of births: \_\_\_\_\_  
Number of miscarriages/abortions: \_\_\_\_\_

**Lungs:** Short of breath  
Wheezing

\_\_\_\_\_/\_\_\_\_\_  
Cough  
Pain with breathing

**Skin:** Rash  
Changing moles

History of abnormal Pap? Yes / No

**Preventative Medical History:** Please list the month and year you last had the following:

Pap: \_\_\_\_\_ Mammogram: \_\_\_\_\_ Bone Density: \_\_\_\_\_

Prostate Exam / PSA: \_\_\_\_\_ / \_\_\_\_\_ Colonoscopy: \_\_\_\_\_ Complete Physical: \_\_\_\_\_

Vaccinations: Hepatitis A: (total of 2 shots) \_\_\_\_\_ Hepatitis B: (series of 3 shots) \_\_\_\_\_ Tetanus: \_\_\_\_\_

Pneumonia: \_\_\_\_\_ Flu: \_\_\_\_\_ Other: \_\_\_\_\_