New Patient History

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Name: ____ Age___________ Date of Birth_____________________

Gender: F M

Please describe the problem or problems that brought you here today:

Please list health concerns you have had in the past and illnesses or disorders you have been diagnosed with:

Please list any injuries or accidents you have had:

Please list any surgeries or hospitalizations:

Have you ever had any possible toxic exposures?

Date of last physical exam ______________________

Do you have allergies or sensitivity to any medications or other substances? Y N
If so, please list:

Please list all medications and supplements you are taking presently (use separate page if needed):

Women

Date of last pap test: _______________ Date of last mammogram: _______________________________
If you ever had an abnormal pap or mammogram, please describe:

Are you having periods? __________ Date of last period: ______________ Have your periods changed in timing, duration or heaviness?

How many pregnancies and births have you had? ____

Were there any complications with your pregnancies? ____

Were the births___________ Vaginal or ____________ C-section?

Are you currently using birth control and if so, what kind? _________________________________

Men

Have you had a prostate screening examination? _______________ Was it normal? ______________

Have you had a PSA test? _________ If so, when? _____________ What was your PSA level? _____________

Social History

Married Single Divorced Widowed Partnered Other:

Do you work outside the home? ____________ If so, what do you do? _____________________________________

Highest education level reached: ____

Do you have children? ____________ Ages? _______________________ Living with you? _________________

Do you have a supportive social network? ____

Do you smoke? __________ If so, how many packs per day? ________________
Did you used to smoke? __________ If so, how many packs per day? ________________________
When did you quit? _______________

Do you drink alcohol? __________________ If so, how much and how often? ____________________
Drink of choice? ____________________________

Do you exercise? _________________ If so, what do you do and how often? ___________________________________

Do you feel you sleep well? ___________ How many hours do you need to sleep to feel rested? ___________ How many hours do you usually sleep?______________

Describe the level of stress you are experiencing in your life. What do you do to help cope?

What lifestyle habits do you currently engage in that you feel support you health?

What lifestyle habits to you currently engage in that you feel may harm your health?

What obstacles do you foresee that could undermine your progress toward better health?

Briefly describe your diet on a typical day and indicate around what time you eat:

Breakfast:
____

Lunch:
____

Dinner:
____

Snacks:
____

About how much water do you drink in a day?

Do you drink soda and if so, how much?

How much coffee do you typically drink in a day?

Family Health History: Please indicate health problems of your immediate family (mother, father, brothers, sisters, children):

Diabetes
High Blood Pressure
Heart Disease/Attack
Bleeding Disorders
Osteoporosis
Cancer (type if known)

Kidney Disease	Depression
Seizure Disorders	Thyroid problems
Other:	

From the following list of symptoms, please circle those that pertain to you presently:

Morning Fatigue	Evening Fatigue	Excess Stress	High Cholesterol
Hot Flashes	Night Sweats	Vaginal Dryness	Incontinence
Foggy Thinking	GERD	Shortness of Breath	Dizziness
Frequent Colds	Rapid Aging	Chest Pain/Pressure	Heart Palpitations
Disturbed Sleep	Bone Loss	Uterine Fibroids	Infertility Problems
Indigestion	Constipation	Excess Gas/Bloating	Decreased Stamina
Slow Pulse Rate	Hair Loss	Weight Gain	Thinning of Skin
Hoarseness	High Triglycerides	Breast Tenderness	Irritable
Anxious	Mood Swings	Decreased Libido	Bleeding Changes
Nervous	Tearful	Fibromyalgia	Water Retention
PMS	Chronic Fatigue	Sleep Apnea	Forgetfulness
Hearing Loss	Goiter	Rapid Heart Beat	Sugar Craving
Allergies	Asthma	Headaches	Aches and Pains
Puffy Eyes or Face	Cold Body Temperature		Fibrocystic Breasts
Weight Gain in the Waist	Weight Gain in the Hips		Increased Facial/Body Hair
Decreased Sweating	Nails Breaking or Brittle		Decreased Muscle Size
Sensitivity to Chemicals	Difficulty Achieving or Maintaining an Erection		
Frequent Urination	Acne		

Other (Please specify):