NEW PATIENT HISTORY AND PHYSICAL

Date _____

Name _____ Age _____ Date of Birth _____

Weight _____ Height _____

Chief Complaint _____

Current Medications	Purpose	Allergies	Reactions

Surgeries	Dates

Have you ever had a major injury? Yes No

Do you bruise or bleed easily? Yes No

Have you had any health issues in the last 5 years? Yes No

Do you take any of the following medications? ____ Aspirin ___ Motrin ___ Naproxen

___ other anti-inflammatory medication ___ Plavix ___ Coumadin ___ Warfarin ___ Vit E

Have you ever had a mammogram? Yes No Results _____

Have you had a tubal ligation? Yes No

Do you have or have you ever had any of the following:		
Diabetes	Yes	No
Tuberculosis	Yes	No
Kidney Disease	Yes	No
High Blood Pressure	Yes	No
Lung problems or pneumonia	Yes	No
Heart or Circulatory Disease	Yes	No
Heart Attack	Yes	No
Thyroid problems	Yes	No
HIV/AIDS	Yes	No
Liver Disease/Hepatitis	Yes	No
Blood/bleeding problems	Yes	No
Cancer	Yes	No
Arthiritis	Yes	No
Cough up blood	Yes	No
Vomit blood/blood in stool	Yes	No
Shortness of breath	Yes	No
Skin disorders	Yes	No
Stomach problems	Yes	No
Heart palpitations	Yes	No
Emotional problems	Yes	No
Dry eyes/vision problems	Yes	No
Problems with healing	Yes	No

Social History

Marital status? **S M D W**

Do you have any children? Yes No

# of children _____ Ages _____

Do you use tobacco? Yes No

Type _____ How much a day? _____ How many years? _____

Do you drink alcohol? Yes No

___ Daily ___ Weekly ___ Socially ___ Occasionally ___ Rarely ___

Are you employed? Yes No Homemaker Self-employed

Family History

Is there a family history of breast cancer? Yes No _____

Is there a history of other cancers in your family? Yes No _____

Is there a family history of diabetes? Yes No _____

Is there a family history of heart disease or hypertension? Yes No _____