NEW PATIENT HISTORY AND PHYSICAL

Date_____

Name_____ Age_____ Date of Birth_____

Weight_____ Height_____

Chief Complaint_____

Current Medications	Purpose

Allergies	Reactions

Surgeries	Date

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
Heart or circulatory disease	Yes	No
Heart attack	Yes	No
Lung problems or pneumonia	Yes	No
Thyroid problems	Yes	No
HIV / AIDS	Yes	No
Liver disease or hepatitis	Yes	No
Blood or bleeding problems	Yes	No
Cancer	Yes	No
Arthritis	Yes	No
Cough up blood	Yes	No
Vomit blood or blood in stools	Yes	No
Shortness of breath	Yes	No
Heart palpitations	Yes	No
Skin disorders	Yes	No
Stomach problems	Yes	No
Emotional problems	Yes	No
Any eyes or vision problems	Yes	No
Problems with healing	Yes	No

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 __Naprosen __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**

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
there a family history of breast cancer? Yes No _____
there a history of other cancers in your family? Yes No _____
there a family history of diabetes? Yes No _____
there a family history of heart disease or hypertension? Yes No _____