



NEW PATIENT EVALUATION

MEDICAL HISTORY: PLEASE FILL OUT AS ACCURATELY AS POSSIBLE

NAME: _____ DOB: ___ / ___ / ___ DATE: ___ / ___ / ___

Reason for today's visit: _____

Who referred you to our office? _____

What physicians are you currently seeing? _____

List medications you are allergic to and the side effects: _____

List immunizations you have received and when they were administered: _____

List all major illnesses or infections and the dates that they occurred: _____

List all surgeries and hospital stays: _____

History of serious diseases in your family? What types (cancer, heart disease, stroke)?

Primary language spoken? _____ Primary language spoken at home? _____

Birthplace: _____ Hand dominance: (circle one) Right Left Ambidextrous

Education Level: _____ Degree Obtained _____

Employment: _____ Occupational Hazards: _____

Military Experience: Y / N If yes, which branch of service? _____

How many years served? _____ Status: AD RET RES Other: _____

Type of discharge: _____ Stationed overseas? Y / N

If stationed overseas, where? _____

Occupational Hazards: _____

Marital Status/Family/Social Support:

Current Marital Status: _____ Previously widowed: Y / N Previously Divorced: Y / N

Have Children: Y / N

Who do you live with? _____ Who compromises your support group?

Do you use tobacco? Y / N Former smoker? Y / N Number of Years: _____
Tobacco use per day: _____ What type of tobacco did you use? _____

Do you drink alcohol? Y / N Formerly? Y / N Type of alcohol drank? _____

Frequency: _____ Amount: _____ Last Drink _____

Caffeine: Y / N Frequency and Amount: _____ Type: _____

Activity Level: _____ Health club member: Y / N

Exercise frequency and typer of exercise: _____

Do you have a religious affiliation: Y / N Do you have spiritual beliefs? Y / N

Do you practice your religion? Y / N Is religion important in your life? Y / N

Changes in sleeping patterns? Y / N Hobbies: _____

Animals in the home? Y / N Type of animal: _____

Smoke detector in home? Y / N Carbon monoxide detectors in home? Y / N

Radon in the home? Y / N Firearms in home? Y / N Seatbelt use? Y / N

Recent Travel: _____

Exposure during your travels? _____

Have you ever been exposed to tuberculosis, when and where? _____

Have you been sexually active in the last 6 months, how many partners, male or female or both? _____

Female patients only: when was your last menstrual cycle? _____

Last PAP smear/pelvic exam? _____ Could you be pregnant? **Y / N**

Have you ever had an HIV or "AIDS" test? When? _____

Have you ever shared needles for injecting drugs? **Y / N**

If yes, please describe: _____

Have you ever had sex for money? **Y / N**

Do you have any tattoos? **Y / N** If yes, how many? _____

Please list all medications you are currently taking including how many times a day and the dosage:

