New Patient History Worksheet Page #1

NAME: _____

Past Medical History / Hospitalizations / Surgeries:

1. Has patient ever been hospitalized? (what for? when?) _____
2. Has patient ever had surgery? (what kind? when?) _____
3. Any chronic medical problems? _____

Medications / Allergies:

1. Note any regular medications (prescription, OTC, herbal, vitamin, supplements, energy drinks) _____
2. Note any allergies or intolerances (drugs, foods, clothing, latex, insects, pets) _____ _____

Social History:

1. Patient lives in house, apartment, trailer, farm, other? _____
2. With whom? Mom/ Dad, Siblings – how many, ages _____ Others? _____
3. Smokers in the home? _____ Inside/outside? Has patient ever tried tobacco products? _____
4. Has patient ever tried alcoholic beverages? _____ Illegal Drugs? _____
5. Any pets? Inside / outside? How many, type? _____
6. Water source? City, well, other? _____ Lead Exposure? Old paint, highway/factory nearby? ____
7. Any history of abuse? Physical, Emotional, Verbal, Sexual, Neglect, Other? _____
8. TEENS: boyfriends/girlfriends? _____

Family History:

1. Any significant illness in Mom/Dad, siblings? _____
2. Grandparents alive/ deceased – cause of death, serious health concerns? _____
3. Mother's height? _____ Father's height? _____
4. Any family very short? _____ Very tall? _____Underweight? _____ Overweight? _____
5. Any extended family with GENETIC DISEASES, such as Sickle Cell, Cystic Fibrosis, Hemophilia? _____

Review of Systems: please circle if "yes" and slash through if "no"

1. General: fever/chills; excessive weight gain/loss, fatigue
2. Eyes: watery or red eyes, vision concerns, crossing/wandering eyes, excessive blinking
3. ENT: runny nose, nasal congestion, sneezing, sore throat, bad breath, cavities, hearing concerns
4. Resp: shortness of breath, wheezing, cough – productive, dry, constant, night-time
5. CV: palpitations, chest pain, fainting, exercise intolerance, history of murmur
6. GI: stomach pain, constipation, diarrhea, vomiting, indigestion, reflux, blood in stool
7. GU: urinary frequency, pain urinating, genital pain, urinary bleeding, incontinence day/night
8. Derm: rash, itchy skin, problems with hair or nails, bumps
9. Psyc: depression, anxiety, trouble concentrating, anger management problems
10. Msk: joint swelling, muscle pain, leg cramps, numbness or tingling in hands/feet, history of scoliosis
11. Heme: easy or excessive bruising or bleeding, bloody noses
12. Gyn (females only): menarche age ____, breast pain, nipple discharge, irregular or heavy cycles