# NEW PATIENT HISTORY FORM

Patient Name: _____ DOB: _____

**Please list ALL Medications you are currently taking, including <u>over the counter</u> and <u>skin creams/ointments</u>: (Please bring your medicines to your appointment)**

_____ _____

_____ _____

_____ _____

_____ _____

**List any medication ALLERGIES (including LATEX):**

_____ _____

_____ _____

**What type of work do you do?**

_____

| | | | |
|---|---|---|---|
| Do you have mold/mildew or water leaks in your home? | | ☐ Yes | ☐ No |
| Do you use a fireplace, wood or pellet stove? | | ☐ Yes | ☐ No |
| Do you have an air conditioner? | | ☐ Yes | ☐ No |
| Do you have pets? | | ☐ Yes | ☐ No |
| What kind? | ☐ Dogs | ☐ Cats | ☐ Other |
| Do they come inside? | | ☐ Yes | ☐ No |
| Are you a current smoker? | | ☐ Yes | ☐ No |
| Have you smoked in the past? | | ☐ Yes | ☐ No |
| Is there smoking at home (indoor or outdoor)? | | ☐ Yes | ☐ No |

If you smoke or have smoked:
Number of packs per day: _____ Number of years _____

# NEW PATIENT HISTORY FORM

Patient Name: _____ DOB: _____

**Please check all that are appropriate:**

## REVIEW OF SYSTEMS

| | | | |
|---|---|---|---|
| Systemic: | ☐ feeling tired/fatigued | ☐ fevers or chills | ☐ other |
| Cardiovascular: | ☐ high or low blood pressure | ☐ irregular heart rhythm | |
| | ☐ swollen ankles (edema) | ☐ heart failure | |
| | ☐ Chest pain/angina/heart attack | | ☐ other |
| Gastrointestinal: | ☐ abdominal pain | ☐ heartburn | |
| | ☐ vomiting | ☐ diarrhea | ☐ other |
| GU: | ☐ difficulty urinating | ☐ pain with urination | ☐ other |
| Endocrine: | ☐ diabetes/high blood sugars | ☐ thyroid problems | ☐ other |
| Hematologic: | ☐ anemia | ☐ swollen lymph nodes | ☐ other |
| Musculoskeletal: | ☐ muscle aches/pains | ☐ swollen joints | ☐ other |
| Neurological: | ☐ headaches | ☐ dizziness | ☐ other |
| Psychological: | ☐ depression | ☐ anxiety | ☐ other |
| Skin: | ☐ itching | ☐ rash | ☐ other |

## FAMILY HISTORY

Is there a history of any of the following in your immediate family (parents or siblings)?

| | | | |
|---|---|---|---|
| Environmental allergies | ☐ Yes | ☐ No | Who? _____ |
| Food allergies | ☐ Yes | ☐ No | Who? _____ |
| Eczema | ☐ Yes | ☐ No | Who? _____ |
| Asthma | ☐ Yes | ☐ No | Who? _____ |
| Recurrent infections | ☐ Yes | ☐ No | Who? _____ |
| Hives | ☐ Yes | ☐ No | Who? _____ |