New Patient Health History Form

Name: _____Today's Date:_____/_____/_____

Date of Birth: _____/_____/_____PCP: _____

Allergies and Medications:

Medication allergies:_____

List any other allergies:_____

Current Medications:

Medication	Dose/Frequency	Used to Treat	For How Long?
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Past Medical History (please check those which apply):

□Hypertension
□Heart Disease
□Hyperlipidemia
□Nerve/Muscle disease
□Stroke
□Seizures
□Migraine
□Fibromyalgia
□Chronic Pain (>3 months)
□Diabetes Mellitus
□GERD/Ulcers/Gastritis
□Depression
□Motor Vehicle Accident
□Thyroid Disease
□Pulmonary
□Kidney Disease
□Anxiety
□Substance Abuse
□Cancer
□Work Related Injury
□Fractures
□DVT
□Prostate Problems

□Nerve/Muscle Disease (please specify):_____

Any other relevant medical history:_____

Family History (please place a check mark indicating relation of relative)

Status:	Alive	Deceased	Unknown	No Known Issues	Arthritis	Cancer	Depression	Diabetes	Early Death (<50yo)	Heart Disease	High Blood Pressure	Lung Disease	Neurological Disorder	Osteoporosis	Stroke	Spine Problems	Drug/Alcohol Abuse	Thyroid Disease	
Mother																			
Father																			
Sister																			
Brother																			
Maternal Grandmother																			
Maternal Grandfather																			
Paternal Grandmother																			
Paternal Grandfather																			
Daughter																			
Son																			

Other relevant family history:_____

Surgical History (please check those which apply and provide approximate year performed):

□Appendectomy_____ □Gall Bladder _____ □Neck Surgery_____
□Back Surgery_____ □Heart Surgery _____ □Orthopedic and/or Joint
□Breast Surgery_____ □Hernia Repair _____ Surgery_____
□C-Section_____ □Hysterectomy_____ □Tonsillectomy _____
Any other relevant surgical history:_____

Social History

1. Marital status: □Married □Domestic Partner □Widowed □Never Married □Divorced/Separated
2. Whom do you live with: □Spouse □Children □Parents □Roommate(s) □Partner
   □Alone □Other_____
3. Highest grade or level of education completed: _____
4. Tobacco Use: □Never □Current □Former (Quit Date: _____)
   a. Type(s) of tobacco used: □Cigarettes □Cigars □Pipe □Chewing Tobacco
   b. Average number of packs per day: _____ Age when started using tobacco: _____
5. Cups of coffee per day? _____ Cups of other caffeinated beverages per day? _____
6. Do you use alcohol? □Yes □No If so, average number of alcoholic beverages per week:_____
   a. Times in the past year you consumed 4+ drinks in one day: _____
   b. Do you use alcohol to control your pain? □Yes □No
7. Drugs you have used:
   a. at any time: □Stimulants □Hallucinogens □Marijuana □Cocaine □Meth □None of these
   b. in the past 12 months: □Stimulants □Hallucinogens □Marijuana □Cocaine □Meth □None of these
8. Are you currently employed? □Yes □No
   a. If so, how many hours per week do you work? _____
   b. Where do you work?_____
   c. What type of work do you do?_____
9. Are you currently on disability or involved in a disability claim? □Yes □No
10. Are you currently involved in a legal claim? □Yes □No
    a. If so, are you represented by an attorney? □Yes □No If yes, please provide name:_____

Review of Symptoms (Check all those which apply):

☐ Low Back Pain	☐ Dizziness	☐ Fever	☐ Wheezing
☐ Joint Pain	☐ Headaches	☐ Weight Loss	☐ Coughing
☐ Joint Swelling	☐ Urinary Frequency	☐ Night Sweats	☐ New Rash
☐ Muscle Pain	☐ Loss of Control of Urine	☐ Vision Change	☐ Psoriasis
☐ Night Pain	☐ Loss of Control of Bowels	☐ Double Vision	☐ Skin Breakdown
☐ Numbness	☐ Constipation	☐ Difficulty Swallowing	☐ Depressed Mood
☐ Tingling	☐ Nausea	☐ Chest Pain	☐ Sleep Problems
☐ Weakness	☐ Vomiting	☐ Palpitations	☐ Anxiety
☐ Falls	☐ Black Stools	☐ Shortness of Breath	