New Patient Medical History

Patient Name _____ Today's Date _____

Date of Birth _____

Chief Complaint: _____

PATIENT MEDICAL HISTORY
Have you had, or do you have, any of the following medical problems:

Diabetes……	No	Yes	Heart Surgery……..	No	Yes
Hypertension……	No	Yes	Heart Attack…….	No	Yes
Breast Cancer……..	No	Yes	Angioplasty……	No	Yes
Colon Cancer……...	No	Yes	Pacemaker/AICD……..	No	Yes
Other Cancer……	No	Yes	Stent……	No	Yes
			Cardiac Arrest……...	No	Yes
Stroke……	No	Yes	Congestive Heart Failure……..	No	Yes
Arthritis……	No	Yes	Valvular disease……	No	Yes
Convulsions……..	No	Yes			
Bleeding tendency……	No	Yes	Tuberculosis……	No	Yes
Acute Infections……...	No	Yes	Asthma…….	No	Yes
Venereal disease……..	No	Yes	Emphysema…….	No	Yes
Abnormal PAP……	No	Yes			
Hepatitis/Jaundice……	No	Yes	**PREVIOUS SURGERIES/HOSPITALIZATIONS**		**DATES**
Liver/Pancreas disease……	No	Yes			
Kidney Stones……..	No	Yes	_____		_____
Urinary Tract infection……..	No	Yes			
Sickle Cell……	No	Yes	_____		_____
Anemia…….	No	Yes			
Received Blood transfusion……	No	Yes	_____		_____
			_____		_____

PATIENT SOCIAL HISTORY

Marital Status:	Single ___	Married ___	Separated ___	Divorced ___	Widowed ___
Alcohol Use:	Never____	Rarely_____	Moderate_____	Daily_____	
Tobacco Use:	Never____	Previously___	Type/frequency_____		
Drug use:	Never____	Previously___	Type/frequency_____		

FAMILY MEDICAL HISTORY

	Age	**State of Health**	**Age at Death**	**Cause of Death**
Father	_____	_____	_____	_____
Mother	_____	_____	_____	_____
Brothers	_____	_____	_____	_____
	_____	_____	_____	_____
Sisters	_____	_____	_____	_____
	_____	_____	_____	_____

_____ _____

Stephen P. Maniscalco MD Date
John W. Davis III, MD
Jack Lai PA-C

Charlie F. Dendy DO Date
Matthew Marcus McTague DO
J. Alan Przybyla, MD

7/2010sp

New Patient Medical History

Patient name_____ **Date of Birth**_____ **Todays Date**_____

CONSTITUTIONAL SYMPTOMS

Good general health lately…….	No	Yes
Recent weight change……	No	Yes
Fever…….	No	Yes
Fatigue……..	No	Yes
Headaches……....	No	Yes

EYES

Eye disease or injury……	No	Yes
Wear glasses/contact lenses……	No	Yes
Blurred or double vision…….	No	Yes
Glaucoma…….	No	Yes

EARS, NOSE, MOUTH, THROAT

Hearing loss or ringing……	No	Yes
Earaches or drainage…….	No	Yes
Chronic sinus problems or rhinitis……..	No	Yes
Nosebleeds……	No	Yes
Mouth sores…….	No	Yes
Bleeding gums……	No	Yes
Bad breath or bad taste…….	No	Yes
Sore throat or voice change……..	No	Yes
Swollen glands in neck……	No	Yes

CARDIOVASCULAR

Heart trouble or murmur……..	No	Yes
Chest pain or angina pectoris……	No	Yes
Palpitations…….	No	Yes
Shortness of breath walking or lying flat	No	Yes
Swelling of feet, ankles, or hands……	No	Yes

RESPIRATORY

Chronic or frequent coughs……..	No	Yes
Spitting up blood…….	No	Yes
Shortness of breath……	No	Yes
Asthma or wheezing…….	No	Yes

GASTROINTESTINAL

Loss of appetite……	No	Yes
Change in bowel movements……	No	Yes
Nausea or vomiting……	No	Yes
Frequent diarrhea……..	No	Yes
Painful bowel movements; constipation	No	Yes
Rectal bleeding or blood in stool…….	No	Yes
Abdominal pain or heartburn…….	No	Yes
Peptic ulcer (stomach or duodenal)……	No	Yes

GENITOURINARY

Frequent urination……..	No	Yes
Burning or painful urination……..	No	Yes
Blood in urine……..	No	Yes
Change in force of strain when urinating	No	Yes
Incontinence or dribbling……	No	Yes
Kidney stones……..	No	Yes

MEN ONLY:

Testicle pain……	No	Yes

WOMEN ONLY

Age of first period_____
# of Pregnancies_____
Age of first pregnancy_____
Age of Menopause_____

PSYCHIATRIC

Memory loss or confusion……..…	No	Yes
Nervousness……..….	No	Yes
Depression……..	No	Yes
Insomnia……..……	No	Yes

INTEGUMENTARY (skin and breast)

Rash or itching……..	No	Yes
Change in skin color……	No	Yes
Change in hair or nails…….	No	Yes
Varicose veins……	No	Yes
Breast pain……	No	Yes
Breast lump…….	No	Yes
Breast discharge…….	No	Yes

NEUROLOGICAL

Frequent or recurring headaches……..	No	Yes
Light-headed or dizziness……..	No	Yes
Convulsions or seizure……	No	Yes
Numbness or tingling sensations……..	No	Yes
Tremors…….	No	Yes
Paralysis……	No	Yes
Stroke……...	No	Yes
Head injury……..	No	Yes

ENDOCRINE

Glandular or hormone problem……..	No	Yes
Thyroid disease…….	No	Yes
Diabetes……..	No	Yes
Excessive thirst or urination…….	No	Yes
Heat or cold intolerance…….	No	Yes
Skin becoming drier……	No	Yes
Change in hat or glove size……..	No	Yes

HEMATOLOGIC/LYMPHATIC

Slow to heal after cut…….	No	Yes
Bleeding or bruising……	No	Yes
Anemia…….	No	Yes
Phlebitis…….	No	Yes
Past blood transfusion…….	No	Yes
Enlarged glands……..	No	Yes
Hepatitis A B C……	No	Yes
Jaundice……	No	Yes

Stephen Maniscalso MD **DATE**
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