New Patient Information

Date: **Name:** **Age:** **Date of Birth:**

Last **First** **M.I.** **(Preferred)**

Family History

Have any members of your immediate family (biological parents or siblings) had any of the following? If YES, please explain and indicate which member by using the appropriate abbreviation:
M= Mother **F** = Father **S**= Sister **B**= Brother circle all that apply

YES **NO**

- ☐ ☐ History of cancer, Melanoma, Breast, Colon, Prostate, Other:_____
- ☐ ☐ High cholesterol, hypertension or Heart disease (Explain)_____
- ☐ ☐ Diabetes, Thyroid Disease (Explain)_____
- ☐ ☐ Lung problem, Asthma (Explain)_____
- ☐ ☐ Colon or stomach problems- ulcers, gall stones, colon polyps, ulcerative colitis Other:_____
- ☐ ☐ Neurologic or Psychiatric or addictive disorder (Explain)_____
- ☐ ☐ Kidney, Prostate or Bladder problems (Explain)_____
- ☐ ☐ Blood or skin problems, Glaucoma (Explain)_____

Other:

Past Personal Medical History

YES **NO** Do you have a past medical history of the following

- ☐ ☐ Cancer (Explain)_____
- ☐ ☐ Blood pressure, heart or lung or cholesterol problem (Explain)_____
- ☐ ☐ Thyroid or blood sugar problems (Explain)_____
- ☐ ☐ Blood clots severe migraine headaches (Explain)_____
- ☐ ☐ Stomach, colon, liver problems (Explain)_____

Other:_____

Past Procedures

YES **NO** In the last 10 years have you had any of the following procedures? Circle ALL that apply and fill in date.

- ☐ ☐ Chest X-ray Date:_____ Result:_____
- ☐ ☐ Heart Test (stress test, heart catheterization, etc.): Date:_____ Result:_____
- ☐ ☐ EKG Date:_____ Result:_____
- ☐ ☐ Stomach Test(upper GI X-ray, Upper Endoscopy, etc.) Date: _____Result:_____
- ☐ ☐ Kidney Test(IVP, cystoscopy, etc.) Date: _____Result:_____
- ☐ ☐ Gall Bladder Test Date: _____Result:_____
- ☐ ☐ Colon Tests(flexible procto, barium enema, colonoscopy, etc.) Date: _____Result:_____
- ☐ ☐ Breathing Test(spirometry, pumonary function, etc.) Date :_____Result:_____
- ☐ ☐ CT Scan Date:_____Result:_____
- ☐ ☐ MRI Scan Date:_____ Result:_____

Other:_____

Prior Hospitalization Or Surgery

Reason: _____Location:_____ Date:_____
Will or Have your records been sent to us? Y N
Reason: _____Location:_____ Date:_____
Will or Have your records been sent to us? Y N

List Of Health Care Providers Seen Within The Last Two Years

Provider: _____Specialty:_____ Will or Have your records been sent to us? Y N
Provider: _____Specialty:_____ Will or Have your records been sent to us? Y N

Do You Experience Current Medical Complaints With Your…

YES **NO**

- ☐ ☐ Eyes, ears throat, lungs? (Explain)_____
- ☐ ☐ Severe headaches, fatigue, dizziness? (Explain)_____
- ☐ ☐ Chest or heart or breasts? (Explain)_____
- ☐ ☐ Stomach, abdomen or colon? (Explain)_____

Other:_____

Immunization Diary- Indicate date of last shot.

Flu:	Measles:	Tetanus:
Hepatitis B:	Pneumovax:	BCG (T.B. Vaccine):
Tuberculosis(TB) Skin Test:	Results:	Other Vaccines: