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New Patient History Form

Please answer these questions to the best of your ability. The information provided will help Dr. White take better care of you. This information is confidential and will not be released without your consent.

Name _____ Date _____ Birth Date _____

Age _____ Gender _____ Occupation _____ Marital Status _____

What is the reason for your visit? _____

Circle any of the following you have had and enter the approximate date or age:

High Blood Pressure _____ Heart Disease _____

Diabetes _____ High Cholesterol/Triglycerides _____

Lung Disease _____ Kidney Disease _____

Jaundice _____ Pneumonia/Asthma _____

Tuberculosis _____ Chicken pox infection or vaccine _____

Thyroid Disease _____ Orthopedic Problems _____

Depression _____ Anxiety _____

Glaucoma _____ Macular Degeneration _____

Cancer _____ Skin Cancer _____

Other Medical Problems: _____

Are you allergic to any medications? Please list them along with the reaction you had:

List all medications (including over the counter and herbal remedies): _____

List any serious injuries: _____

List any surgeries or hospitalizations. Please give year or approx. date and treating MD:

Indicate whether you have had any of the following procedures and the approximate year.

Cardiac Stress _____ Bone Density Test _____ Colonoscopy _____ Flex Sig _____

Immunizations are an important part of your total health picture.

What have you had and when? Tetanus _____ Pneumovax _____ Flu _____

Hepatitis B (this is a 3 shot series) _____ MMR booster _____ Shingles _____

OB-GYN History:

Number of pregnancies _____ Number of living children _____ Number of miscarriages _____

Please explain any **unusual** items about your pregnancy history such as ectopic pregnancies, stillbirths, abortions, and etc: _____

Menstrual History:

Age at onset of periods _____ If you are post-menopausal, skip to the next section.

Periods occur how frequently? _____ Are they regular or do they skip around? _____

Periods last how many days on average? _____ Your last period was when? _____

Your menstrual flow is: Heavy Moderate Light

Menstrual cramps are: Heavy Moderate Light

Do you need medical help with your cramps? Yes No

PMS symptoms are: Severe Moderate Mild None

Do you need medical help with your PMS? Yes No

Menopause: (Complete this section only if you are post-menopausal)

About what age were you when you entered menopause? _____

Have you ever taken hormones? No Yes Are you on hormones now? No Yes

Have you ever had unexplained post-menopausal bleeding? No Yes

History: Pap Smear

Have you ever had a Pap smear? No Yes When was your last Pap smear? _____

Have your Pap smears always been normal? No Yes

Has your cervix ever been treated because of an abnormal Pap smear? No Yes

If yes, what kind of treatment? Cryosurgery (freezing) _____ LEEP _____ Conization _____

Other _____

Contraception:

Are you in a sexual relationship? No Yes If not or you are menopausal, go to next section.

How are you preventing a pregnancy? (circle one)

Birth control pills the 3-month shot tubal ligation vasectomy condoms other

Infections:

It's ok if you would rather talk with Dr. White about these sensitive issues and not answer these questions in writing.

Have you ever had a sexually transmitted disease? No Yes

Which one? Chlamydia: No Yes Human Papilloma Virus: No Yes

Herpes: No Yes Genital Warts: No Yes

Other GYN-related questions:

Is there a history of sexual molestation, date, rape, etc? No Yes
 Do you have any of the following symptoms? Vaginal discharge Vaginal odor
 Do you douche? No Yes

FAMILY HISTORY

(Remember this is about your family not you.)

	Year of Birth	Medical Conditions	Age of Death	Cause of Death
Mother	_____	_____	_____	_____
Father	_____	_____	_____	_____
Brother	_____	_____	_____	_____
Brother	_____	_____	_____	_____
Sister	_____	_____	_____	_____
Sister	_____	_____	_____	_____

Indicate the medical conditions your blood kin have had (place relationship in blank):

High Blood Pressure _____ Heart Attack _____ Stroke _____
 High Cholesterol _____ Diabetes _____ Stomach Ulcer _____
 Depression _____ Nervous Breakdown _____ Alcoholism _____
 Other Addictions _____ Arthritis _____ Asthma _____
 Osteoporosis _____ Migraines _____ Tuberculosis _____
 Colitis _____ Kidney Disease _____ Liver Disease _____
 Leukemia _____ Sickle Cell Anemia _____ Bleeding Tendency _____
 Breast Cancer _____ Ovarian Cancer _____ Colon Cancer _____

Additional Comments: _____

Tobacco Use:

Yes No Do you use any type of tobacco products? If not, skip to alcohol section.
 Yes No Do you dip or chew?
 Yes No Have you ever smoked?
 Yes No do you smoke now? If “yes”, how many packs per day? _____
 Age you started smoking? _____ Are you interested in quitting? _____
 If you’ve stopped, age you stopped? _____

Alcohol Use:

Yes No Do you ever have alcoholic beverages? If “no” go to next section.
 Yes No Do you have more than 3 drinks per week?

Yes No Have you ever cut back on your alcohol consumption?

TELL US ABOUT YOURSELF!

Education: (last high school grade completed, GED, College, post graduate)

List all the people who live at home with you (list name, relationship to you & year of birth)

Hobbies: _____

SAFETY:

Yes No Do you wear seat belts?
Yes No Are there handguns in your home?
Yes No Do you keep handguns locked and away from kids?

Exercise:

Yes No Do you exercise?
Yes No Do you exercise at least 30 minutes three times a week?

Place a CHECK by any of the listed symptoms that **currently** apply to you:

Skin, Hair & Nails

___ Color Changes
___ Itching
___ Moles
___ Infections
___ Rash
___ Hair/Nail Change

Constitutional

___ Weakness
___ Fatigue
___ Fever
___ Chills
___ Night Sweats
___ Change in Appetite

Breast

___ Lumps
___ Pain
___ Discharge
___ Fibrocystic
___ Monthly Exam
___ Last Mammo

Eyes

___ Vision Changes
___ Pain/Infection
___ Wear Glasses/Contacts
___ Date of last eye exam

Ears

___ Pain
___ Discharge
___ Hearing Loss
___ History of infections

Teeth

___ Problems
___ regular Dental care
___ Floss daily
___ Brush twice a day

Blood

___ Anemia
___ Easy Bruising
___ Enlarged Glands
___ Excessive Bleeding
___ Blood Transfusion
___ Year of transfusion

Endocrine

___ Goiter
___ Heat intolerance
___ Cold intolerance
___ Palpitations
___ Change in voice
___ Frequent urination
___ Excessive Thirst
___ Overeating
___ Weight Gain
___ Weight Loss

Respiratory

___ Cough
___ Sputum
___ Shortness of breath
___ Wheezing
___ Pleurisy
___ Asthma
___ Spitting up Blood
___ Seasonal Allergy
___ last chest x-ray
___ Inhaler use?

___ Abnormal Hair Growth
___ Infertility

___ Date of skin TB test

Musculoskeletal

___ Joint Pain
___ Joint Heat
___ Joint Redness
___ Joint Stiffness
___ Joint Injury
___ Bone difficulty
___ Muscle Spasm
___ Muscle Tenderness
___ Morning Stiffness
___ Height Loss
___ Osteoporosis
___ Spine Problems

Cardiovascular

___ Chest Pain
___ Shortness of breath lying down?
___ How many pillows for sleep?
___ Palpitations
___ High Blood Pressure
___ History of Rheumatic Fever
___ Calves hurt when walking
___ Fingers or toes hurt when cold
___ Antibiotics must be used prior to dental work
___ Shortness of breath on exertion?
___ Shortness of breath at night
___ Swelling of Feet
___ Fainting Spells
___ Heart murmur
___ Varicose Veins
___ Mitral Valve Prolapse
___ Was MVP confirmed by an echocardiogram? (ultrasound of the heart)

Gastrointestinal

___ Appetite Change
___ Nausea
___ Vomiting
___ Difficulty Swallowing
___ Indigestion
___ Excessive Gas
___ Vomiting Blood
___ Abdominal Pain
___ Jaundice
___ Use of Antacids
___ Diarrhea
___ Constipation
___ Blood in Stool/Toilet Tissue
___ Hemorrhoids
___ Hernia
___ Use of Laxatives
___ Frequent bowel movements
___ Change in bowel habits

Depression

___ Crying Spells
___ Nervousness
___ Anxiety
___ Nightmares
___ Insomnia
___ Feelings of guilt
___ Poor Self Esteem

Nervous System

___ Convulsions/Seizure
___ Faintness
___ Incontinence
___ Stroke
___ Speech Difficulty
___ Dizziness
___ Tremor
___ Trouble Walking
___ Change in Sensation
___ Transient Blind Spells
___ Loss of Coordination
___ Numbness
___ Tingling
___ Trouble rising from chair
___ Migraines
___ Other types of headaches
___ Carpal Tunnel Syndrome
___ Tennis Elbow

Urinary Tract

___ Frequent infections
___ Small urinary stream
___ Can't hold urine
___ Backache
___ Pain w/urination
___ Kidney Stones
___ Blood in Urine
___ Frequency

The Relationship Chart:

During the past 4 weeks, how often have problems in your household led to:

Insulting or swearing? Yelling? Threatening? Hitting or Pushing

None of the time	A little of the time	Some of the time	Most of the time	All of the time
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Patient Signature _____ Date _____

Reviewed by _____ **Date** _____