

Your Name, MD
Your Practice Name

Name _____

Today's Date ____/____/____

NEW PATIENT HISTORY FORM

PLEASE LIST YOUR PRIMARY CARE PHYSICIAN

NAME	SPECIALTY	CITY, STATE	DATE LAST SEEN

LIST ANY OTHER PHYSICIANS YOU SEE

NAME	SPECIALTY	CITY, STATE	DATE LAST SEEN
	OB/GYN		

WHY ARE YOU SEEING US TODAY? _____

MEDICAL HISTORY *Have you or members of your family had any of the following:*

CONDITION	YOU	FAMILY
High Cholesterol		
Heart Disease/Attack		
Rheumatic Fever		
High Blood Pressure		
Stroke		
Blood Clots		
Asthma		
Tuberculosis		
Diabetes		
Thyroid Problems		
Liver Disease		
Hepatitis		
Gallstones		

CONDITION	YOU	FAMILY
Arthritis		
HIV/AIDS		
Kidney/Bladder Problem		
Anemia		
Blood Transfusion		
Bleeding Disorder		
Breast Disease		
Breast Cancer		
Ovarian Cancer		
Colon Cancer		
Birth Defects		
Genetic/Inherited		

OTHER MEDICAL HISTORY _____

PREVIOUS SURGERIES *(Include C-Sections and Tubal Ligations)*

YEAR	OPERATION	HOSPITAL	COMMENTS

CURRENT PRESCRIPTION MEDICATIONS

NAME	DOSAGE	TIMES PER DAY	HOW LONG?

CURRENT NON-PRESCRIPTION MEDICINES *(Include Herbals and Supplements)*

NAME	DOSAGE	TIMES PER DAY	HOW LONG?

MEDICATION ALLERGIES

	NAME	REACTION	

SYMPTOM CHECKLIST

Instructions: Please note the symptoms in the list that you experience on a regular basis. Place an “X” in the column corresponding the **frequency** and **severity** of each symptom.

If you *rarely* have the symptom, just leave that line **blank**.

Symptom Frequency

1=A Few days a Month
2=A Few days a Week
3=Almost Every Day

Symptom Severity

1=Mildly Noticeable
2=More Bothersome
3=Severe/Debilitating

SYMPTOM	1	2	3		1	2	3
Aches & Pains							
Fatigue (All-Day)							
Fatigue (Morning)							
Fatigue (Afternoon)							
Fatigue (Evening)							
Irritability							
Mood Swings							
Foggy Mind							
Anxiety							
Can't Fall Asleep							
Interrupted Sleep							
Waking Up Unrefreshed							
Carb. Cravings							
Depression							
Heavy Periods							
Cyclic PMS Symptoms							
Breakthrough Bleeding							
Hot Flashes							
Breast Tenderness							
Headaches							
Bloating							
Night Sweats							
Low Sex Drive							
Weight Gain							
Vaginal Dryness							
Hair Loss							
Dry, Thinning Skin							
Cold Body Temperature							

Just Check →
“Severity” →
for Each of These →
Symptoms →

LIFESTYLE QUESTIONS

Do you smoke cigarettes? ____ YES ____ NO If so, how many cigarettes per day? _____

Do you drink alcohol? ____ YES ____ NO If so, how many drinks per week? _____

Do you use any street drugs? ____ YES ____ NO *(all answers are confidential)*

How many caffeine-containing drinks do you have a day? _____ *(coffee, tea, sodas, energy drinks)*

What time do you go to bed at night? _____ How long until you fall asleep? _____

How many times do you wake up a night? _____ Do you go to sleep with the TV on? _____

What do you do when you wake up at night? _____

What time do you wake up in the morning on a typical work day? _____

Do you take anything to help you fall asleep? _____

Do you eat after 8PM? ____ YES ____ NO Do you feel refreshed when you wake up? _____

Do you exercise for at least 30 minutes at a time, at least 3 days per week? ____ YES ____ NO

What do you do for exercise? _____

What time of day do you usually exercise? _____

How many meals a day do you eat? ____ Do you snack between meals? ____ YES ____ NO

Do you drink at least 64 ounces of water per day? ____ YES ____ NO

What prescription diet pills have you taken in the past? _____

What was your most successful diet? _____ How much did you lose? _____

How much weight would you realistically like to lose in the next year? _____ pounds.

STRESS QUESTIONS

- Please **circle** all current stressors in your life.

MOVED YOUR HOME

JOB CHANGE

JOB STRESS/LOSS

ILL FAMILY MEMBERS

MARITAL PROBLEMS

DIVORCE/SEPARATION

DEATH OF SPOUSE/CHILD

FORECLOSURE/BANKRUPTCY

LEGAL PROBLEMS

NEW MARRIAGE

RETIREMENT

TROUBLE W/ IN-LAWS

PROBLEMS WITH CHILDREN

NEW PERSON LIVING WITH YOU

THANK YOU. THIS CONCLUDES OUR QUESTIONNAIRE