9/15/2019

SHORT NEW PATIENT HISTORY FORM

NAME:_______________________________________ AGE: ___ DATE: __________ TIME: ________ am/pm

OCCUPATION:____

A. MAJOR SYMPTOMS

Be a good storyteller. What are your major symptoms and problems for which you have come to us today? Please explain. In describing your symptoms, think of duration, i.e., how long you have been having it, how severe it is, its frequency (how often you experience it).

B. TREATMENT RECEIVED

1. Tell us about the **treatment you have received** for the problems you have mentioned above, such as the physicians consulted, investigations, and the tests that you had (including x-rays, CT scans, blood tests), and medicines used - prescription or over-the-counter medicines, etc.

C. Review of Systems:

Do you experience any of the following symptoms? If so, rate each of the following symptoms based upon your typical health profile.

4 = Frequently have it, effect is severe	1 = Occasionally have it, effect is not severe
3 = Frequently have it, effect is not severe.	0 = Never or almost never have the symptom
2 = Occasionally have it, effect is severe	(Put your check rating in numbered column.)

1.	**Digestive:**	5.	**Muscles/Joints:**
	Constipation		Muscle aches/muscle pain/muscle spasms; where: forearms, fingers, thighs, legs/feet, neck generalized (encircle all that apply)
	Diarrhea or loose stool		
	Gas		
	Belching		Muscle cramps/charley horses
	Bloating		Low back pain/spasm
	Abdominal pain		Pain/tightness in upper back
	White, coated tongue		Pain/tightness in neck, shoulder area
	Heartburn		Joint pains, where: Shoulders, elbows, wrists, hands, hips, knees, ankles, foot, multiple joints (encircle all that apply).
	Indigestion		
	Bad breath		
2.	**Headaches, Emotions, & Mind:**	6.	**Cardiovascular:**
	Headaches		High blood pressure
	Depression		Rapid heartbeat
	Anxiety		Irregular or skipped heartbeat
	Fear		Palpitations
	Nervousness		
	Irritable or angry easily	7.	**Nose:**
	Become aggressive easily		Stuffy nose
	"Fly off the handle"		Runny nose
	Reduced memory		Hay fever
	Reduced concentration		Sneezing attacks
	Head pressure		Postnasal drip
	Difficulty thinking clearly		Sinus infections
	Mood swings		
	Difficulty in making decisions	8.	**Lungs**
	Confusion		Wheezing
	Poor comprehension		Asthma
	Learning difficulties or learning disabilities		Difficulty in breathing
	Hyperactivity		Chest tightness
	Restlessness		Chest congestion
	Insomnia		Shortness of breath
	Drowsiness		Chronic cough
3.	**Energy/Activity:**	9.	**Urinary Tract:**
	Tire easily/fatigue/low level of energy		Frequent urination
	Tired by the end of the day		Burning on urination
	Wake up tired		Awaken at night to urinate
	Sleep excessively		
	Feel excessively cold	10.	**For Women Only:**
	Weight gain		
			Have ever had vaginal yeast infection. If yes, total number of yeast infections in your lifetime ______.
4.	**Skin:**		
	Cold hands		Vaginal discharge
	Cold feet		Premenstrual symptoms, a few to several days before menstruation. If yes, what premenstrual symptoms do you have?
	Dry skin		
	Acne		
			• Premenstrual headaches
			• Premenstrual depression
			• Premenstrual irritability
			• Premenstrual anxiety
			• Premenstrual bloating
			• Premenstrual fluid retention
			• Other premenstrual symptoms (please specify)
11.	**PAST MEDICAL HISTORY FOR BOTH MEN AND WOMEN: Have you ever been diagnosed with any of the following?**		

	(Check what applies to you.)		
	Hypothyroidism (low thyroid).		Mitral valve prolapse
	Goiter (enlarged thyroid)		Irritable bowel syndrome
	High cholesterol		Gallstones
	High triglycerides		Alcoholism
	Diabetes		Drug abuse
	Hypoglycemia		Endometriosis (women)
	Fibromyalgia		Fibrocystic breast (women)

12. Are you allergic to any medicines? ______ Yes ______No
13. List medicines you are currently taking: ____
____

D. ENVIRONMENTAL AND SOCIAL HISTORY (Encircle that applies):

1. I smoke; I do not smoke; Smoking at home by: _________________; Have dog; cat; Gas stove; Gas dryer
2. Tell us about your habits regarding drinking and drugs:

3. Encircle exposures at work: Tobacco smoke; Dusts; Fumes; Mists; Vapors; Solvents; Gases; Asbestos

4. Do any of the following smells bother you: Yes No

Tobacco smoke (987.8), exhaust fumes (980.3), bleaches, detergents, soaps (989.6), ammonia, odor of new carpeting, asphalt, tar, pine odor, moth balls, insect sprays, pesticides, weed killers, fungicides, paints, varnishes, shellac, perfumes, hair sprays, cosmetics, air fresheners, gasoline products (980.3), natural gas, new cars, furniture polish, floor wax, candle odor, burning incense, rubbing alcohol (980.2), disinfectants, household cleaners, rubber, plastics, chlorinated water (987.6), newsprint, magic markers, new fabric stores, spray cans, food odors like cooking food or frying food, alcohol, formaldehyde, cedar wood/cedar chips, smoke from wood burning or fireplace, sulfur, latex, mold/mildew odor, odors in salons and beauty parlors, potpourri, burning leaves, just about odors of any kind. *(encircle the odors that bother you)*

5. Did you ever have **<u>any surgery</u>** such as tonsillectomy, adenoidectomy, tubes in the ears, sinus surgery, gall bladder, appendectomy, hysterectomy, ovaries removed, breast operations, hernia (encircle that applies)? Other:
____

E. Family History:

1. Tell us if you have any health problems in your family: Allergies, Asthma, Sinus, Hay fever, Headaches, Fatigue, Arthritis, High blood pressure, Heart disease, Diabetes, Breast cancer, Other cancer, Low Thyroid (Encircle that applies)
Other: ____

<u>USE THIS SPACE FOR ADDITIONAL INFORMATION</u>