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NEW PATIENT HISTORY FORM

DATE: _____

TIME: _____

NAME: _____ AGE: _____ OCCUPATION: _____

DATE OF BIRTH: _____ SEX: _____ MARITAL STATUS: S M W D

CHIEF COMPLAINT: _____

LIST PRESENT MEDICATIONS:

LIST ALLERGIES TO MEDICATIONS:

PERSONAL HISTORY:

YOUR HOSPITALIZATIONS:

YEAR:

HOSPITAL:

Illness (kind)		
Surgery (kind)		

YOUR CHILDREN:

Living _____

List any serious disease in children: _____

Deceased _____

Cause: _____

YOUR PERSONAL HABITS:

DO YOU? YES NO AMOUNT

Use Illegal Drugs?			
Use Alcohol?			
Smoke ?			

If you quit smoking, when? _____

IN CONNECTION WITH TODAY'S VISIT

	YES	NO		YES	NO		YES	NO
HEARING LOSS			COUGH			NASAL OBSTRUCTION		
RINGING IN EARS			SORE THROAT			NOSE BLEED		
DRAINING EARS			HOARSENESS			DENTURES		
EAR ACHE			DIFFICULTY SWALLOWING			HEADACHE		
DIZZINESS			NECK LUMP					

FAMILY HISTORY:

Cause of Death

Your Father	Alive		
	Deceased		
Your Mother	Alive		
	Deceased		
Your Siblings	Alive		
	Deceased		

DO YOU HAVE A FAMILY HISTORY OF:

	YES	NO
HEART DISEASE		
HIGH BLOOD PRESSURE		
DIABETES		
STROKE		
CANCER (LOCATION?)		
THYROID DISEASE		
HEARING DISORDERS		
BLEEDING		
ANESTHESIA PROBLEMS		

BLOOD PRES	PULSE	RESPIRATION	TEMPERATURE	HEIGHT	WEIGHT

Reviewed by Physician: _____