Name: ______________________________

NEW PATIENT COMPREHENSIVE EXAMINATION FORM

Chief Concerns:____

____

List ongoing Medical illnesses below (such as diabetes, hypertension):

1.______________________________ 4.___________________________

2.______________________________ 5.___________________________

3.______________________________ 6.___________________________

List any medications that have caused an **allergic reaction** (rash, shortness of breath, or shock) ________________ ____________________ ___________________

List medications that you do not **tolerate**: _______________ ________________
_______________ ________________

Date of Immunizations:

Pneumovax: _____________ Prevnar______________ Tetanus: ______________

Hepatitis A vaccine:______________ Hepatitis B vaccine: ____________________

Tuberculosis (PPD) test:___________ Influenza______________

Other vaccines:____

Family History

	Alive/Age	Health Problems	Deceased/Age	Cause of Death
Father	_________	_____________	____________	_____________
Mother	_________	_____________	_____________	_____________
Brothers	_________	_____________	_____________	_____________
	_________	_____________	_____________	_____________
Sisters	_________	_____________	_____________	_____________
	_________	_____________	_____________	_____________
Sons	_________	_____________	_____________	_____________
	_________	_____________	_____________	_____________
Daughters	_________	_____________	_____________	_____________
	_________	_____________	_____________	_____________

Name: ______________________________

PERSONAL HISTORY

(Please circle or answer below where appropriate)

Marital Status: Single Married Divorced Widowed
Occupation: ______________________________
Living Will: Yes No
Tobacco: None
Currently smoke_______packs/day and have done so for______years
Previously smoked_____packs/day for_____years stopped in______
Use chewing tobacco: Yes No

Alcohol: None
Liquor: number of ounces per day________
Beer: number of cans/bottles/day________
Wine: number of glasses/day____________

Substance Abuse: None currently abuse previously abused
What substance? ______________________

Caffeine(coffee, tea, caffeinated soda): None Number of 8oz servings a day ________

Exercise: Type__________________________________ amount per week_________

Diet: No specific diet, diabetic, weight reduction, low saturated fat, low salt

CURRENT MEDICATIONS
Please Bring All Medications With You (In The Bottles) And List All Of The Information Below:

Med. Name/Strength	How Med. Taken	Number of Refills
1.___________________	1. __________________	1. ______________
2.___________________	2. ___________________	2. _______________
3.___________________	3. ___________________	3. _______________
4.___________________	4. ___________________	4._________________
5.___________________	5. ___________________	5. ________________
6.___________________	6. ___________________	6. ________________
7.___________________	7. ___________________	7. ________________

Preferred Pharmacy:
Local:____

Mail Order: ____

Name:___________________________

List Surgeries, major hospitalizations, accidents (with dates):

1.____________________________ 4.___________________________

2.____________________________ 5.____________________________

3.____________________________ 6.____________________________

Date of last complete physical exam: ____________________________________

Date of last cholesterol blood test: _____________ Result (if known) __________

Date of last eye exam:____________ Eye Doctor:__________________________

Have you had your stool checked for blood? Yes No When______
Flexible Sigmoidoscopy Yes No When_______
Barium Enema Yes No When_______
Colonoscopy Yes No When_______

Date of last EKG: ______________ Date of last Chest x-ray:___________

Any other heart (cardiac) studies: ____

For Women only:

Date/Result of last gynecological exam (breast and pelvic):____________________

Name of Gynecologist:____

Date of last menstrual period:____________ Date of last pap smear_____________

Have you had previous abnormal pap smears? ___________

Date/Result of last mammogram:______________________

Date/Result of last bone density scan:__________________

For Men only:

Date of last prostate exam:____________

Date of last PSA:____________________ Result (if known) __________

Name: ______________________________

1. GENERAL: Change in activity and energy, appetite change, weight change, fever, chills, night sweats

2. HEAD: Headache, trauma

3. EYES: Visual changes, double vision

4. EARS: Ringing, hearing loss, infection, drainage, pain

5. NOSE/THROAT: Nose bleed, gum bleeding, tongue soreness, difficulty swallowing, hoarseness

6. LUNGS: Shortness of breath, cough, wheezing, coughing up blood

7. HEART: Chest pain, heart skips, rapid heart rate, exertional shortness of breath

8. ABDOMEN: Stomach pain, sour taste in throat, nausea, vomiting, diarrhea, constipation, black stools, blood in stool

9. URINARY: ***Men***: Difficulty in urination, blood in urine, prostate enlargement, sexual problems, penile discharge
   Women: Painful urination, increase in frequency of urination, blood in urine, vaginal discharge, vaginal bleeding outside of normal menstrual cycle, menopause, vaginal dryness, hot flashes, mood swings

10. JOINTS/MUSCLES: Pain in joints, pain in muscles, weakness joint swelling, Backache

11. NEUROLOGICAL: Dizziness, loss of consciousness, transient loss of function in arms and legs, seizures

12. SKIN: Rashes, non-healing lesions, history of skin cancer

13. BREAST/CHEST: Breast lumps or tenderness, chest wall tenderness

14. EMOTIONAL: Nervousness, mood swings, depression, difficulty coping

15. ENDOCRINE: Thyroid trouble, heat or cold intolerance, diabetes, excessive thirst, hunger or urination

16. BLOOD/GLANDS: Anemia, easy bruising, easy bleeding, swollen glands

EXPLANATIONS: ____

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