**New Patient Information Form**

Today's Date: ____ / ____ / _____

Patient Name: _____ DOB:_____

Preferred Pharmacy: _____Pharmacy Phone Number:_____

| **Medications (Please include over the counter meds, supplements, and vitamins)** | | | |
|---|---|---|---|
| Drug | Dosage | Directions | Reason |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

| **Allergies** |
|---|
| Medications: No ____ Yes ____ (please describe): |
| Allergic to Latex? No ____ Yes ____ (please describe): |
| Allergic to Iodine? No ____ Yes ____ (please describe): |

| **Past Surgical History** | |
|---|---|
| Surgery | Date |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |

Patient Name: _____ DOB: _____ Date: _____

| **Past Medical History** | | | |
|---|---|---|---|
| | Yes | | Yes |
| Anemia or Blood Disorder | | Arthritis -- ***Type?*** | |
| Asthma | | Back Pain | |
| Cancer – ***Type?*** | | COPD | |
| Depression | | Glaucoma | |
| Diabetes Type I | | GERD without Esophagitis | |
| Diabetes Type II | | GERD with Esophagitis | |
| Gout | | Headache/Migraine | |
| Heart Disease | | Heart Attack | |
| Hepatitis B | | Hepatitis C | |
| High Cholesterol | | High Blood Pressure | |
| HIV / AIDS | | Kidney Stones | |
| Malignant Hyperthermia | | MRSA | |
| Osteoporosis | | Peptic Ulcer | |
| Seizures | | Sleep Apnea | |
| Stroke | | Thyroid Disorder | |
| Varicose Veins | | | |

| **Do you have or have you had any of the following symptoms related to your present condition?** | |
|---|---|
| Weight loss: Yes No | Change in urinary / bowels habits: Yes No |
| Weight gain: Yes No | Abdominal pain: Yes No |
| Fever / chills / night sweats: Yes No | Difficulty sleeping: Yes No |
| Dizziness: Yes No | Weakness or numbness in the arms/ legs: Yes No |
| Nausea / Vomiting: Yes No | Joint Stiffness: Yes No |
| Bruising: Yes No | Muscle Aches: Yes No |
| Chest Pain: Yes No | Trauma to: Arm(s) Leg(s) Hip(s) Knee(s) Ankle(s) |
| Blood clots: Yes No | Swollen Joints: Yes No |

| Family Medical History | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Mother | Father | Brother | Sister | Son | Daughter | Spouse | | | |
| Brain Aneurysm | | | | | | | | | | |
| Cancer-- ***Type?*** | | | | | | | | | | |
| Diabetes | | | | | | | | | | |
| Heart Disease | | | | | | | | | | |
| HIV | | | | | | | | | | |
| High Cholesterol | | | | | | | | | | |
| High Blood Pressure/ Hypertension | | | | | | | | | | |
| Alive | | | | | | | | | | |
| Deceased | | | | | | | | | | |

Patient Name: _____ DOB: _____ Date: _____

| Social History | |
|---|---|
| Alcohol Use | Never ____ Current ____ Former ____ |
| Tobacco Use | Never ____ Current ____ Former ____ How Much ____ |
| Drug Use | Do you use recreational drugs? Yes ____ No ____ |
| Occupation | |
| Marital Status | Married ____ Divorced ____ Single ____ Widowed ____ |
| Advanced Directive | Yes ____ No ____ |
| Injection Date | Flu shot: _____ Pneumonia Shot: _____ |

| Please list all other Physicians involved in your care (Pain Management, Cardiology, etc.) | |
|---|---|
| Physician's Name | Reason for seeing Physician |
| | |
| | |
| | |
| | |
| | |

| How did you hear about Dr. Morgan? (Check all that apply) | |
|---|---|
| Primary care doctor ☐ | Pain management doctor ☐ |
| Chiropractor ☐ | Other doctor ☐ |
| Patient ☐ | Friend ☐ |
| Internet ☐ | Magazine ☐ |
| Newspaper ☐ | Radio ☐ |
| Billboard ☐ | Other ☐ |