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 us? (Check all that apply)	
Primary care doctor ☐	Pain management doctor ☐
Chiropractor ☐	Other doctor ☐
Patient ☐	Friend ☐
Internet ☐	Magazine ☐
Newspaper ☐	Radio ☐
Billboard ☐	Other ☐