## NEW PATIENT INFORMATION FORM

Today's Date _____ / _____ / _____

What is the reason for your visit today? _____

_____

_____

Where have you been receiving your medical care?

Name of Physician _____

Address _____

**PAST MEDICAL HISTORY:** Please circle Yes or No for any illnesses that you have had:

| | | |
|---|---|---|
| Anemia | Yes | No |
| Arthritis | Yes | No |
| Asthma / Bronchitis / Emphysema | Yes | No |
| Bleeding / Bruising | Yes | No |
| Cancer (type) | Yes | No |
| Depression / Emotional Problems | Yes | No |
| Drug / Alcohol Dependency | Yes | No |
| Heart Problems | Yes | No |
| Immune Disorders | Yes | No |
| Kidney Disease | Yes | No |
| Lung Disease | Yes | No |
| Skin Disease | Yes | No |
| High Blood Pressure | Yes | No |
| Thyroid Disease | Yes | No |
| Other (describe) | Yes | No |

Have you ever been hospitalized? If yes, please list the date(s) and reason(s):

_____

_____

Have you had any surgeries? If yes, please list the date(s) and reason(s):

_____

_____

Please list any medications you take, including prescription drugs, over-the-counter drugs, eye drops, vitamins, minerals, and herbs:

_____

_____

Have you ever had an allergic reaction to a medication? If yes, which medication(s)?

_____

_____

Do you use or take any drugs such as marijuana, cocaine, stimulants, or sedatives?

_____

_____

Instructions to Provider: Your signature below indicates that you have reviewed the information contained in this questionnaire and you have reviewed the pertinent or key findings with the patient and/or family. Key findings must be summarized in your progress note; however, the questionnaire may be referenced for additional details.

Signature_____Date _____ / _____ / ___