NEW PATIENT HISTORY FORM

Patient Name: DOB:

**Please list ALL Medications you are currently taking, including over the counter and skin creams/ointments: (Please bring your medicines to your appointment)**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**List any medication ALLERGIES and reaction to those medications (include LATEX):**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**What type of work do you do?**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have mold/mildew or water leaks in your home?  Yes  No

Do you use a fireplace, wood or pellet stove?  Yes  No

Do you have an air conditioner?  Yes  No

Do you have pets?  Yes  No

What kind?  Dogs  Cats  Other

Do they come inside?  Yes  No

Are you a current smoker?  Yes  No  Tobacco  Cannabis

Have you smoked in the past?  Yes  No

Is there smoking at home (indoor or outdoor)?  Yes  No

If you smoke or have smoked:

 Number of packs per day: \_\_\_\_\_\_\_\_ Number of years \_\_\_\_\_\_\_\_

 Page 1

NEW PATIENT HISTORY FORM

Patient Name:  DOB:

**Please check all that are appropriate:**

REVIEW OF SYSTEMS

Systemic:  feeling tired/fatigued  fevers or chills  other

Cardiovascular:  high or low blood pressure  irregular heart rhythm

  swollen ankles (edema)  heart failure

  Chest pain/angina/heart attack  other

Gastrointestinal:  abdominal pain  heartburn

  vomiting  diarrhea  other

GU:  difficulty urinating  pain with urination  other

Endocrine:  diabetes/high blood sugars  thyroid problems  other

Hematologic:  anemia  swollen lymph nodes  other

Musculoskeletal:  muscle aches/pains  swollen joints  other

Neurological:  headaches  dizziness  other

Psychological:  depression  anxiety  other

Skin:  itching  rash  other

FAMILY HISTORY

Is there a history of any of the following in your immediate family (parents or siblings)?

Environmental allergies  Yes  No Who? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Food allergies  Yes  No Who? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Eczema  Yes  No Who? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Asthma  Yes  No Who? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Recurrent infections  Yes  No Who? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Hives  Yes  No Who? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Page 2