New Patient History Form

PATIENT INFORMATION

Patient Name (Last, First, Middle)	MRN	SSN#	Birthdate	Language	Sex
Address	City, State, Zip		Referring Physician	Secondary Address	Ethnicity
Home Phone	Day Phone	Email Address	Primary Care Prov	City State Zip	Race
Marital Status	Smoker (Y/N?)	Veteran (Y/N?)	Emergency Contact Name	Contact Phone	Home Phone

Primary Employer & Occupation	Secondary Employer (If Applicable)
Address	Address
City, State, Zip	City, State, Zip

RESPONSIBLE PARTY INFORMATION (If different than above)

Name (Last, First, Middle)	SSN#	Birthdate	Language	Sex
Address	City, State, Zip		Secondary Address	

Home Phone	Day Phone	Email Address	City, State, Zip
Marital Status	Veteran (Y/N?)	Primary Care Physician	Home Phone
Relationship to Patient			

PRIMARY INSURANCE

Name of Insurance Company		Policy #	
Name of Insured		Group #	
Address of Insurance Company		Copay Amt $	
City, State, Zip	Phone	Deductible $	
Relationship to Patient		Effective Date	Expiration Date

SECONDARY INSURANCE (If applicable)

Name of Insurance Company		Policy #	
Name of Insured		Group #	
Address of Insurance Company		Copay Amt $	
City, State, Zip	Phone	Deductible $	
Relationship to Patient		Effective Date	Expiration Date

R 11/3/2013

SIH MEDICAL GROUP

New Patient History Form

Patient Medical History/Conditions
(Please check all that apply)

Patient Name: ______________________
Medical Record #: ______________________
Date: ________________________________

Allergies:

- ☐ None
- ☐ Penicillin
- ☐ Sulfa Drugs
- ☐ IVP Dye
- ☐ Foods: ________________
- ☐ Other: ________________

Medications:

____
____
____
____
____
____
____
____
____

Preferred Pharmacy:

____
Name

____
City

Reason For Visit

____
____
____
____

Past Medical History:

- ☐ Allergies
- ☐ Anemia
- ☐ Angina
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ Benign Prostatic Hypertrophy
- ☐ Blood Clots
- ☐ Cancer (type)____________
- ☐ CVA (stroke)
- ☐ COPD
- ☐ Coronary Artery Disease
- ☐ Crohn's Disease
- ☐ Depression
- ☐ Diabetes
- ☐ Gallbladder Disease
- ☐ GERD
- ☐ Hepatitis C
- ☐ Hyperlipidemia
- ☐ Hypertension
- ☐ Irritable Bowel Disease
- ☐ Liver Disease
- ☐ Migraine Headaches
- ☐ Myocardial Infarction
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Peptic Ulcer Disease
- ☐ Renal Disease
- ☐ Seizure Disorder
- ☐ Thyroid Disease

Past Surgical History

- ☐ Angioplasty
- ☐ Angioplasty with stent
- ☐ Appendectomy
- ☐ Arthroscopy knee
- ☐ Back Surgery
- ☐ CABG (Heart Bypass)
- ☐ Carpal Tunnel Release
- ☐ Cataract Extraction
- ☐ Cholecystectomy (Gall Bladder)
- ☐ Colectomy
- ☐ Colostomy
- ☐ Gastric Bypass
- ☐ Hernia Repair
- ☐ Hip Replacement
- ☐ Knee Replacement
- ☐ Lasik
- ☐ Liver Biopsy
- ☐ ORIF
- ☐ Pacemaker
- ☐ Small Bowel Resection
- ☐ Thyroidectomy
- ☐ Tonsillectomy
- ☐ Other: ______________

Gender Specific:

- ☐ Prostate Biopsy
- ☐ TURP
- ☐ Vasectomy
- ☐ Hysterectomy

Preventative Care

- ☐ Last Colonoscopy ______________
- ☐ Last Mammogram ______________
- ☐ Last Pap Smear ______________

SIH MEDICAL GROUP

New Patient History Form

Family History

(Please check all that apply)

Patient Name: ______________________

Medical Record #: ______________________

Date: ______________________________

☐ ADD/ADHD	☐ Hearing Deficiency
☐ Alcoholism	☐ Hyperlipidemia
☐ Allergies	☐ Hypertension
☐ Alzheimer's Disease	☐ Irritable Bowel Disease
☐ Asthma	☐ Learning Disability
☐ Blood Disease	☐ Mental Illness
☐ Coronary Artery Disease	☐ Migraines
☐ Breast Cancer	☐ Obesity
☐ Colon Cancer	☐ Osteoarthritis
☐ CVA (stroke)	☐ Osteoporosis
☐ Depression	☐ PVD
☐ Developmental Delay	☐ Renal Disease
☐ Diabetes	☐ Seizure Disorder
☐ Eczema	☐ Thyroid Disorder

Social History

Tobacco Use: Current Former Never

☐ Type: _______________ Packs/cans per day: ___________ Years used: ________

☐ Former : Year quit _______________

Alcohol Use: Yes No Former

If yes, type (circle all that apply):
- Beer
- Wine
- Hard liquor

If yes, Frequency (circle one):
- Socially Daily
- Weekly Rarely

Caffeine Use: Yes No

If yes, type (circle all that apply):
- Coffee/Tea
- Chocolate
- Soda (soft drinks)

If yes, amount per day (circle one):
- 1-2 servings 2-4 servings
- Greater than 4 servings

Occupation: ____

Sexually active? Yes No New partners? Yes No

SIH MEDICAL GROUP

New Patient History Form

Patient Review of Systems

(Please check all that apply)

Patient Name: ______________________

Medical Record #: ______________________

Date: ______________________

Constitutional:
- ☐ Chills
- ☐ Fatigue
- ☐ Fever
- ☐ Malaise
- ☐ Night Sweats
- ☐ Weight Gain
- ☐ Weight Loss

HEENT:
- ☐ Ear Drainage
- ☐ Ear Pain
- ☐ Eye discharge
- ☐ Eye Pain
- ☐ Hearing Loss
- ☐ Nasal Drainage
- ☐ Sinus Pressure
- ☐ Sore Throat
- ☐ Visual changes

Respiratory:
- ☐ Chronic cough
- ☐ Cough
- ☐ Known TB exposure
- ☐ Shortness of breath
- ☐ Wheezing

Cardiovascular:
- ☐ Chest Pain
- ☐ Claudication
- ☐ Edema
- ☐ Palpitations

Gastrointestinal:
- ☐ Abdominal Pain
- ☐ Blood in Stool
- ☐ Change in bowel habits
- ☐ Constipation
- ☐ Diarrhea
- ☐ Heartburn
- ☐ Loss of appetite
- ☐ Nausea
- ☐ Vomiting

Genitourinary:
- ☐ Dribbling
- ☐ Dysuria – painful urination
- ☐ Hematuria - Blood in Urine
- ☐ Nocturia – night time urination
- ☐ Polyuria – Urgency
- ☐ Slow stream
- ☐ Urinary frequency
- ☐ Urinary Incontinence
- ☐ Urinary retention

Reproductive (Male)
- ☐ Erectile dysfunction
- ☐ Penile discharge
- ☐ Sexual dysfunction

Reproductive (Female):
- ☐ Abnormal Pap
- ☐ Breast Discharge
- ☐ Breast Lump
- ☐ Painful Menses
- ☐ Painful Intercourse
- ☐ Hot Flashes
- ☐ Irregular Menses
- ☐ Vaginal Discharge

Metabolic/Endocrine:
- ☐ Brittle hair
- ☐ Brittle nails
- ☐ Cold intolerance
- ☐ Hair changes
- ☐ Heat intolerance
- ☐ Hirsutism
- ☐ Polydipsia
- ☐ Polyphagia

Neurological:
- ☐ Dizziness
- ☐ Extremity numbness
- ☐ Extremity weakness
- ☐ Gait disturbance
- ☐ Headaches
- ☐ Memory Loss
- ☐ Seizures
- ☐ Tremors

Psychiatric:
- ☐ Anxiety
- ☐ Depression
- ☐ Insomnia

Integumentary:
- ☐ Contact allergy
- ☐ Hives
- ☐ Itching
- ☐ Mole changes
- ☐ Rash
- ☐ Skin lesion

Musculoskeletal
- ☐ Back Pain
- ☐ Joint Pain
- ☐ Joint swelling
- ☐ Muscle weakness
- ☐ Neck pain

Hematologic
- ☐ Easy Bleeding
- ☐ Easy Bruising
- ☐ Lymphadenopathy

Immunologic
- ☐ Environmental allergies
- ☐ Food allergies
- ☐ Seasonal allergies

Date: ______________________ Patient Signature: ______________________

R 11/3/2013