New Patient

Name:_____ Age:____ Pt#_____ Date:_____

WT:____ HT:____ P:___ BP:____ R:____

Allergies:_____ Current Meds:_____

Reason(s) For Today's Visit

CC_____ 4)_____

2)_____ 5)_____

3)_____ 6)_____

History of Present Illness(HPI):[Location, Appearance, Duration, Improving or Getting Worse, Painful or not, Itching or not, Other]

_____

_____

Applicable ROS: Current or Past Problems With

	No	Yes(if yes explain)		No	Yes(if yes explain)
General Health			Arthritis/Muscle/Joints		
Eyes			Skin/Breast		
Ears/Nose/Throat/Mouth			Headaches/Seizures		
Heart			Psychological Disorders		
Lungs			Thyroid/Diabetes		
Stomach/Bowel			Blood/Bleeding Disorder		
Kidneys/Bladder			Allergic/Immunologic		
Additional Comments					

_____

Females: are you pregnant? ___yes ___no Planning to Become Pregnant? ___yes ___no

Applicable Family and Social History: Mother Living/Deceased___ age___ Father Living / Deceased___ age___

Which of the following medical conditions have occurred in your family:

Disease	Mother	Father	Blood Relative	Disease	Mother	Father	Blood Relative
Skin Cancer	O	O	O	Arthritis	O	O	O
Malignant Melanoma	O	O	O	Allergies	O	O	O
Internal Malignancy	O	O	O	Asthma	O	O	O
Other Cancers	O	O	O	Diabetes	O	O	O
Other Tumors	O	O	O	Eczema	O	O	O
Tuberculosis	O	O	O	Psoriasis	O	O	O
Lung Disease	O	O	O	Heart Disease	O	O	O

Reviewed_____ Date_____ Update_____

Physician Signature