NEW PATIENT HISTORY FORM

Name:_____ Birth date: _____

DATE OF APPOINTMENT:_____
WHAT PROVIDER ARE YOU SEEING? Dr. Mary Arenberg ____
Dr. George Schroeder ____

PAST MEDICAL HISTORY (please list year if possible)
Any childhood illnesses:
_____
Past hospitalizations and surgeries:
_____
_____
Previous Medical Problems:
_____
_____
CURRENT MEDICATIONS (please list both prescription and non-prescription):
_____
_____

MEDICATION ALLERGIES AND TYPE OF REACTION: _____
Do you have a history of Latex sensitivity or allergy? Yes No
Do you or any family member have problems with anesthesia? Yes No
Do you or any family member have bleeding problems? Yes No

PERSONAL HISTORY
Marital status: married___ single___ divorced___ widow___
Your occupation: _____
Last year of school completed: _____
Tobacco use: yes___ no___
If yes what age did you start? _____
If yes how many packs per day ? ____
Do you use chewing tobacco? Yes No
Alcohol use:
How many days per week do you drink alcohol? _____
How many drinks per day? _____
How often in the past year have you had 5 or more drinks in a day?_____
Other drug use? _____

FAMILY HISTORY (Please list any illness in your family members such as heart disease, stroke, diabetes, cancer, high blood pressure, high cholesterol, lung disease, liver or kidney disease, depression or suicide)
Father: _____
Mother: _____
Brothers or sisters: _____
Paternal grandfather: _____
Paternal grandmother: _____

Maternal grandfather: _____
Maternal grandmother: _____
Please list your children and any health problems they have:_____

Please check any problems listed below that <u>you have had in the last year</u>:

___ Fever, chills, night sweats, weight loss or gain

___ Headaches, head injuries, concussion

___ Eye problems, do you wear contacts or glasses?

___ Do you have any loose or capped teeth? Dentures?

___ Cold or allergy symptoms, nose bleeds

___ Ear problems, hearing loss, ringing, ear pain

___ Thyroid problems or x-ray treatment to neck or chest

___ Breast masses, breast discharge, breast pain

___ Breathing problems, shortness of breath, asthma, bronchitis, pneumonia, emphysema

___ High blood pressure, rheumatic fever, chest pain, palpitations or skipped beats, heart murmur

___ Heartburn, ulcers, gallstones, constipation, diarrhea, bloody or black bowel movements, abdominal pain

___ Kidney or bladder infection, leaking urine, pain with urination, kidney stones

___ Muscle pain, joint pain or swelling, broken bones, dislocations, muscle weakness

___ Seizure, loss of coordination, tremors, speech problems, memory loss, numbness, tingling

___ Rash, mole change, skin infections, hair loss

___ Abnormal bleeding from any site, clotting problems, bruising easily
Have you ever had any blood transfusions? _____

___ Depression, poor sleeping, appetite problems, panic attacks, suicidal thoughts or attempts

___ Concerns about sexuality or sexual function?

___ (Females age 16 – 55): what was the date of your last menstrual period?

ANY ADDITIONAL CONCERNS YOU WOULD LIKE TO ADDRESS TODAY?

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