New Patient/Annual Update Form

(Medical History/Review of Systems)

Name:_____ **Date of Birth:**_____ **Age:**_____

Height:_____ **Weight:**_____ **Right Handed:**_____ **Left Handed:**_____

Primary Care Physician:_____ **Referring Physician:**_____

Pharmacy:_____

Gender: _____ **Primary Language:** _____

Why are you here today? _____

Was this an: ____ **Auto Accident?** ____ **Work Injury?** **If yes, is there a claim open?** ____ Yes ____No

Please check off and provide date vaccine was administered:

Pneumococcal Vaccination (Over 65 Years of Age): ____ Yes ____ No, Date: _____

Flu Vaccine (All Ages): ____ Yes ____ No, Date: _____

COVID Vaccine ____ Yes ____ No, Date: _____

Medical History: **Check off ONLY Medical Problems You Have** **If No Medical Problems, NONE:** ____

___ Arthritis	___ High Blood Pressure	___ Thyroid Disease	___ Kidney Stone	___ H.I.V.
___ Emphysema/COPD	___ Treatment for Addiction	___ Ulcer Disease	___ Overweight	___ Stroke
___ Diabetes	___ Osteoporosis/Osteopenia	___ Prostate Disease	___ Blood Clots	___ Asthma
___ Heart Disease	___ Heart Arrhythmia	___ Heart Attack	___ Multi. Sclerosis	___ Cancer

___ Others _____

Current Medications and Doses: _____

_____

Medical Allergies: ____None, or _____

Other Allergies: ____ None, or _____

Accidents/Injuries: ____ None, or _____

Prior Surgery: ____ None, or _____

Adaptive Devices: ____ None, or _____

Family History: Medical Problems of Family Members: _____

Father: ____ Alive ____ Deceased, Cause:_____ **Mother:** ____ Alive ____ Deceased, Cause:_____

Number of Children: _____ **Number of Brothers/Sisters:** _____

(Please Complete Side Two)

Social History:

Race/Ethnicity: _____ ____ **Prefer not to answer**

Lives with: _____

Marital Status: _____

Education Level: _____

Occupation: _____

Personal Habits: Do You Smoke? ____None, or How many per day _____
____ Quit, How many years ago _____

How often do you have drinks containing alcohol? ____ None, or _____

Recreational Drug Use: ____ None, or _____

Exercise: ___ None, ___ Once a month, ___ Once a week, ___ Few times a week, ___ Daily

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Review of Systems: Please rate your overall health: ____ Excellent, ____ Good, ____ Fair, ____ Poor

Do you have any of the following symptoms?

__ None. **Constitutional**: __ Fatigue, __ Fever, __ Weight Loss, __ Weight Gain

__ None. **Eyes**: __ Blurred Vision, __Double Vision, __Corrective Lenses

__ None. **Ears/Nose/Throat**: __ Hearing Loss, __ Ringing in Ears, __ Hoarseness, __ Difficulty Swallowing

__ None. **Heart**: __ Chest Pain, __ Irregular Heartbeat, __ Leg Swelling

__ None. **Lungs**: __ Cough, __ Cough Up Blood, __ Shortness of Breath, __ Wheezing

__ None. **G.I.**: __ Abdominal Pain, __ Loss of Appetite, __Constipation, __ Diarrhea, __ Blood in Stool

__ None. **Urinary**: __ Difficulty Voiding, __ Loss of Urine, __Burning, __ Infection

__ None. **Musculoskeletal**: __ Stiffness, __Swelling, __ Muscle Spasms, __ Loss of Strength

__ None. **Skin/Breast**: __ Lumps, __ Masses, __ Rash, __ Sores, __ Skin Ulcers

__ None. **Neurologic**: __ Dizziness, __ Balance Problems, __ Memory Loss, __ Numbness/Tingling

__ None. **Psychological**: __ Anxiety, __ Depression, __ Hallucinations, __ Sleep Disturbance

__ None. **Endocrine**: __ Crave Food, __ Hair Loss, __ Crave Fluids

__ None. **Blood/Lymphatics**: __ Anemia, __ Easy Bruising, __ Enlarged Glands

__ None. **Immunologic**: __ Frequent Colds, __ Frequent Infections

Signature:_____ **Date**: _____