New Patient Forms (copy)

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Date

07/07/2025

DEMOGRAPHICS SHEET

PLEASE COMPLETE FORMS CAREFULLY

MAKE SURE TO ANSWER ALL QUESTIONS. SIGN AND DATE EACH PLACE INDICATED.

Patient's First Name *

Patient's Last Name *

Patient's Date of Birth

MM DD YYYY

Address

Patient Phone Number

(___) ___-____

Social Security Number

Gender *

○ Male ○ Female

Marital Status *

○ Single ○ Married ○ Separated ○ Divorced ○ Widowed ○ Child ○ Other

Occupation

Employer's Name

Employer Phone Number

(___) ___-____

Employer's Address

Referred by:

Referring Physician's Phone and Address if available.

Primary Physician

Name and Phone #

Primary Physician Address

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Doctor's Name | Address | Phone Number

Doctor's Name | Address | Phone Number

Doctor's Name | Address | Phone Number

Doctor's Name | Address | Phone Number

Doctor's Name | Address | Phone Number

Preferred Pharmacy Name *

Preferred Pharmacy Phone

(___)___-____

Preferred Pharmacy Town/ City *

Emergency Contact Name

Relationship

Emergency Contact Phone Number

(___) ___-____

Primary Insurance Policy Name

Policy Holder's Name

Group #

ID#

Policy Holder's Social Security #

Policy Holder Birth Date

MM/dd/yyyy

WORKER'S COMPENSATION or NO FAULT: please enter one

Address

Policy Number

Carrier Case #

Case Manager

Case Manager Phone #

I. What is the main complaint for which you are coming to the office

2. What is the history of your present illness?

a. When did the problem start?

b. Where is the problem located?

c. Has it become

○ worse? ○ better? ○ same?

d. If you have pain, does the pain travel?

○ Yes ○ No

e. Is the problem constant?

○ Yes ○ No

f. If the problem is on and off, is it

○ daily? ○ weekly? ○ monthly? ○ other?

g. What, if anything makes it better?

h. What, if anything makes it worse?

i. What treatments have you had for this problem?

j. Are there any other problems associated with your main problem?

☐ headache ☐ vision ☐ speech ☐ numbness
☐ dizziness ☐ hearing ☐ pain ☐ weakness

A. PATIENT'S GENERAL HEALTH

1. Recent examinations and hospitalizations

2. Past Medical Illnesses

3. Past Surgeries

4. Radiation Therapy

5. Last Tetanus Booster

6. Transfusions

Date	Amount	Reactions (if any)
MM/dd/yyyy		

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7. Have you ever had a tumor or cancer?

○ Yes ○ No

B. Review of systems (check and explain in # 10)

1. HEAD

- ☐ Headache
- ☐ Visual Disturbance
- ☐ Dental Disease
- ☐ Sinusitis
- ☐ Earache
- ☐ Bleeding Gums
- ☐ Head Injury
- ☐ Tinnitus
- ☐ Upper Respiratory Infection
- ☐ Hearing Disturbance
- ☐ Nose Bleed
- ☐ None

2. RESPIRATORY TRACT

- ☐ Pleurisy
- ☐ Sputum
- ☐ Hoarse
- ☐ Wheezing
- ☐ Hiccups
- ☐ Pneumonia
- ☐ Bronchitis
- ☐ TB
- ☐ Chronic Cough
- ☐ Spitting up blood
- ☐ other
- ☐ None
- ☐ Last Chest X-ray

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3. CARDIAC

- ☐ Angina
- ☐ Hypertension (High Blood Pressure)
- ☐ Arrhythmia
- ☐ Cyanosis
- ☐ Heart Murmur
- ☐ Palpitations
- ☐ Edema
- ☐ Dyspnea (difficulty breathing)
- ☐ Enlarged Heart
- ☐ Nocturnal Dyspnea (difficulty breathing at night)
- ☐ None

Last EKG	Special Diagnostic Tests	Results
MM/dd/yyyy		

4. GI *(Gastro-intestinal)*

- ☐ Dysphagia (difficulty swallowing)
- ☐ Anorexia
- ☐ Hemorrhoids
- ☐ Diarrhea
- ☐ Bowel Habit Change
- ☐ Nausea
- ☐ Cramps
- ☐ Heartburn
- ☐ Abdominal Pain
- ☐ Erucation (belching)
- ☐ Constipation
- ☐ Cramps
- ☐ Indigestion
- ☐ Hernia
- ☐ Hematemesis (vomiting blood)
- ☐ Black or blood stool
- ☐ None
- ☐ Other

5. GU *(genito- urinary)*

a. Male/ Female

- ☐ Dysuria (difficulty urinating)
- ☐ Hematuria (blood in urine)
- ☐ Facial Edema (swelling)
- ☐ VD (venereal disease)
- ☐ Nocturia (urinating at night)
- ☐ Urinary Retention
- ☐ Frequency
- ☐ Back Pain
- ☐ Stones
- ☐ None
- ☐ Other

b. Female

- ☐ Menarche
- ☐ Menses Regular
- ☐ LMP
- ☐ Abnormal Bleeding
- ☐ Post Menopausal Bleeding

Last Pap Smear

# of Pregnancies

Abortions

○ Yes ○ No

# of children

6. NEURO- MUSCUAR

- ☐ Dizziness
- ☐ Abnormal Gait
- ☐ Memory Problems
- ☐ Syncope
- ☐ Unconsciousness
- ☐ Weak Spell
- ☐ Vertigo
- ☐ Paresthesias (abnormal sensations)
- ☐ Joint Pain
- ☐ Convulsions
- ☐ Tremor
- ☐ Arthritis
- ☐ None
- ☐ Other

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7. EMOTIONAL

- ☐ Personality Change
- ☐ Nervous Breakdown
- ☐ Depressed
- ☐ Psychiatric Treatment
- ☐ None
- ☐ Other

8. DO YOU HAVE ANY OF THE FOLLOWING

- ☐ DIABETES
- ☐ PACEMAKER
- ☐ DEFRIBRILLATOR

9. SYMPTOMS OR DISEASES NOT LISTED?

☐ NONE

10. EXPLANATION OF CHECKED ITEMS

HABITS

	AMOUNT	HOW LONG	WHEN CHANGED
ALCOHOL			
TOBACCO			

HEIGHT

WEIGHT LBS

GAIN

LOSS

SLEEP HOURS

EATING HABITS

○ GOOD ○ POOR

CURRENT MEDICATIONS (attach a list or write below with doses and times per day)

MEDICATION	DOSAGE	FREQUENCY	MEDICATION	DOSAGE	FREQUENCY

PREVIOUS HEALTH AND ILLNESS

HOW LONG?

PRESENT OCCUPATION

PRIOR WORK

EXPOSURE TO OCCUPATIONAL DISEASE

○ YES ○ NO

WHEN

TRAVEL

1. ALLERGIES

- ☐ Asthma
- ☐ Food
- ☐ Hay fever
- ☐ Urticaria
- ☐ Inhalants
- ☐ Penicillin
- ☐ Drugs
- ☐ NONE
- ☐ Ambien

A. FAMILY HISTORY: Check the condition, and include relevant family member (i.e. mother, father, brother, sister, son, daughter, etc.)

Condition	Family Member	Condition	Family Member
☐ Arthritis		☐ Tuberculosis	
☐ Cancer		☐ Nervous Breakdown	
☐ Psychosis		☐ Leukemia/ Lymphoma	
☐ Epilepsy		☐ Gout	
☐ Gall Bladder Stones		☐ Jaundice	Insurance Company
☐ Thyroid		☐ Coronary Disease	
☐ Kidney Disease		☐ Hypertension	
☐ Allergies		☐ Bleeding Tendency	
☐ Diabetes		☐ Kidney Stones	
☐ Ulcer		☐ Other	
☐ Rheumatic Heart Disease			

B. Mother

○ Living ○ Deceased

C. Father

○ Living ○ Deceased

PATIENT'S SIGNATURE *

DATE

07/07/2025