

TODAY'S DATE _____

New Patient H&P form

LAST NAME _____ FIRST NAME _____ MIDDLE _____

SOCIAL SECURITY NUMBER _____ DATE OF BIRTH _____

CHIEF COMPLAINT (Reason for your visit today) _____

Location of problem (if applicable)

How long does your problem last?
30 minutes 1 hour Always present
Other _____

When did you first notice your problem?

Are there any other symptoms? Y N
If yes, please describe _____

If pain is an issue, please rate your pain on a scale
of 1-10, with 10 being the most severe

1 2 3 4 5 6 7 8 9 10

Does the problem interfere with
your normal functions? Y N

Does anything help or make the problem worse?
Moving around Standing up Lying down
Other _____

If yes, please describe _____

Physician use only:

Past medical history (any other medical illnesses)

Are you on medications? Y N (If yes, list them)

Any past surgeries? Y N (If yes, please list)

Do you have drug allergies? Y N (If yes, explain)

Do you smoke or have you smoked? Y N
If yes, # years _____ Packs/day _____
If you quit, when did that occur? _____

List serious illnesses in your immediate family

Do you drink? Y N
If yes, how much? _____

Physician use only:

Review of Systems

Do you now or have you had any problems related to the following systems? Circle Yes or No.

Please explain any Yes answers in the space provided.

Constitutional				Integumentary		
Weight Gain	Y	N		Skin Bruising	Y	N
Weight Loss	Y	N		Hair Loss	Y	N
Appetite Loss	Y	N		Persistent itch	Y	N
Chills	Y	N		Skin Rash	Y	N
Dietary Changes	Y	N		Boils	Y	N
Fatigue	Y	N				
Fever	Y	N		Respiratory		
				Frequent cough	Y	N
HEENT				Snoring	Y	N
Blurred vision	Y	N		Difficulty breathing	Y	N
Headache	Y	N		Wheezing	Y	N
Double vision	Y	N				
Ear infection	Y	N		Cardiovascular		
Vertigo (dizziness)	Y	N		Chest Pain	Y	N
Nasal congestion	Y	N		Fainting	Y	N
Sore Throat	Y	N		Irregular Heart Beat	Y	N
				Swelling of legs	Y	N
Gastrointestinal						
Chronic diarrhea	Y	N		Genitourinary		
Hemorrhoids	Y	N		Blood in urine	Y	N
Abdominal pain	Y	N		Painful urination	Y	N
Constipation	Y	N		Incontinence	Y	N
Diarrhea	Y	N		Nighttime urination ≥ 2	Y	N
Nausea/Vomiting	Y	N		Sexual Dysfunction	Y	N
Musculoskeletal				Neurological		
Back pain	Y	N		Numbness	Y	N
Joint pain	Y	N		Decreased memory	Y	N
Muscle weakness	Y	N		Tremors	Y	N
Psychiatric				Endocrine		
Depression	Y	N		Excessive thirst	Y	N
Panic attacks	Y	N		Libido change	Y	N
Suicidal ideas	Y	N				
				Hematology		
Other				Abnormal bleeding	Y	N
				Anemia	Y	N
				Blood clots	Y	N
				Swollen glands	Y	N

Physician Use Only: