New Patient Information Form

NAME: _____

Why are you coming for this evaluation? _____

How long have you had this problem? _____

Has it been getting worse? □ yes □ no

What treatments have you tried? _____

MEDICATIONS & SUPPLEMENTS:

Please list all medications you are currently taking (including any over-the-counter medications, vitamins, or herbal supplements/home remedies). Include dosage and how often you take it. If you need more room, please list all medications on a separate sheet of paper and attach it to this packet.

Medication Name	Dosage	How Often

Preferred Pharmacy: _____ Phone: _____

Address/Location: _____

ALLERGIES/MEDICATION REACTIONS:

Are you allergic to latex? □ no □ yes: if yes, please list reaction: _____

Please list all medication allergies or reactions below, including the type of reaction experienced. If you need more room please list all medications & reactions on a separate sheet and attach it to this packet.

Medication Name	**Type of Reaction** (hives/rash, itching, shortness of breath, nausea, etc.)

MEDICAL HISTORY: *Number of*: Pregnancies _____ Vaginal Deliveries _____ C-Sections _____

	Medical Problems	Please check one:		
		Current problem	Past Problem	Never a problem
RESP	Asthma			
	Chronic cough			
	Chronic Obstructive Pulmonary Disease (COPD)			
HEME	Blood clot in leg or arm			
	Blood clot in lung			
	Blood disorder- **circle specific problem** *chronic anemia, von Willebrand's disease, sickle cell trait/disease, thalasemia, hemophilia*			
CARDIAC	Heart Disease- **circle specific problem** *heart attack, coronary artery disease, angina, congestive heart failure, stent placement*			
	Heart Condition- **circle specific problem** *abnormal beats or rhythm, murmur, pacemaker, artificial valves*			
	High Blood Pressure			
	Stroke			
	Transient Ischemic Attack (TIA)			
ENDO	Diabetes - **circle specific treatment** *diet-controlled, oral medications, insulin shots*			
	Thyroid Disease- **circle one**: *hypo- or hyper-*			
GU	Kidney Disease- **circle specific problem** *polycystic kidneys, renal insufficiency, renal failure (on dialysis), anatomic abnormalityof kidneys or ureters*			
	Kidney Stones			
	Recurrent Bladder Infections (UTI)- *> 3/year*			
	Interstitial Cystitis			
	Abnormal Pap Smear- **year**: _____			
GI	Irritable Bowel Syndrome- **circle type** *diarrhea-predominant, constipation-predominant, mixed*			
	Chronic constipation			
	Acid Reflux/chronic heartburn			
	Liver disease- **type**: _____			
MSK	Arthritis- **circle type** *osteo-, rheumatoid, psoriatic*			
	Fibromyalgia			
NEURO	Epilepsy/Seizure Disorder			
	Parkinson's Disease			
	Multiple Sclerosis			

	Medical problems, continued	Current	Past	Never
PSYCH	Depression			
	Anxiety			
	Cognitive Impairment or Dementia			
OTHER	Glaucoma- **circle type:** *wide/open or narrow/closed*			
	Chronic Pain- Location: _____			
	Cancer- **circle type** *breast, cervical, endometrial/uterine, ovarian, bladder, kidney, other:* _____			
	Other: _____			
	Other: _____			

SURGICAL HISTORY:

Please list all past surgeries. I f you need more room, please list all surgeries on a separate sheet and attach to this packet.

Hysterectomy? □ no □ yes: year _____ *Route-* □ *abdominal incision* □ *laparoscopic* □ *vaginal*

Removal of ovaries? □ no □ yes: □ *both* □ *right* □ *left*

Year	Type of Surgery	Surgeon/Hospital	Complications

SOCIAL HISTORY:

Do you…	No	Past Use	Yes	
Use tobacco?		quit date: _____		# packs per day: _____ # years of use: _____
Use recreational drugs?		quit date: _____		Type: _____ How often? _____
Drink alcohol?		quit date: _____		Type: _____ # drinks per week: _____

Occupation: _____ □ retired □ disabled

Are you currently sexually active? □ no □ yes

Have you been sexually abused? □ no □ yes: □ *as a child* □ *as an adult* □ *currently*

Have you been physically abused? □ no □ yes: □ *as a child* □ *as an adult* □ *currently*

Are you a primary caregiver to someone? □ no □ yes: *relationship:* _____

Marital/Relationship status □ married □ single □ divorced □ separated □ other: _____

Who do you live with? □ alone □ spouse/significant other □ family □ other: _____

What is your usual level of physical activity?
□ very active & exercise regularly □ active □ a little active □ not active

What is your current mobility level?
□ walk without any problems or assistive devices □ need a cane or walker
□ need help getting on an exam table □ use a wheelchair

FAMILY HISTORY: □ check here if you are adopted and do not have this information

Has anyone in your family (blood relative) been diagnosed with any of the following?

Medical Problem	Paternal Grandfather	Paternal Grandmother	Maternal Grandfather	Maternal Grandmother	Father	Mother	Brother	Sister	Other
Bleeding or clotting problem *(von Willebrands, hemophilia, platelet disorder, Factor V Leiden)*									
Breast Cancer									
Colon or Rectal Cancer									
Diabetes									
Endometrial or Uterine Cancer									
Heart Attack									
Heart Disease									
Ovarian Cancer									
Stroke or TIA									
Other: _____									
Other: _____									

REVIEW OF SYSTEMS: Circle any of the following symptoms you are currently experiencing:

Constitutional	fever · chills · weight loss · weight gain · malaise/fatigue · sweating · night sweats · weakness
Skin	rash · itching
HENT	headaches · hearing loss · ringing in ears · ear pain · ear discharge · nosebleeds · congestion · sore throat
Eyes	blurry vision · double vision · pain with light in eyes · eye pain · eye discharge · eye redness
Cardiovascular	chest pain · palpitations · shortness of breath with lying down · leg pain with walking · leg swelling · waking up at night short of breath
Respiratory	cough · coughing up blood · productive cough · shortness of breath · wheezing
GI	heartburn · nausea/vomiting · abdominal pain · diarrhea · constipation · blood in stool · dark, tarry stools · bloating
MSK	muscle pain/aches · neck pain · back pain · joint pain · frequent falls
Endo/Heme/Imm	easy bruising/bleeding · allergies · feeling too thirsty
Neuro	dizziness · tingling/numbness · tremor · change in sensation · change in speech · weakness in one arm or leg · seizures · passing out/fainting
Psych	depression · suicidal ideas · substance abuse · hallucinations · anxiety · insomnia · memory loss

UROGYNECOLOGY:

Were you treated for 3 or more bladder infections in the last year? □ no □ yes

Do you have difficulty emptying your bladder? □ no □ yes

Do you have pain when you urinate? □ no □ yes

How many times do you get up to empty your bladder at night?

□ *0 /rarely* □ *1-2* □ *3-4* □ *5 or more*

How often do you have bowel movements?

□ *daily* □ *every other day* □ *1-2 times a week* □ *less than once per week*

Do you leak stool? □ no □ yes: □ *liquid stool* □ *loose stool* □ *soft stool* □ *formed stool*

If you experience **URINARY INCONTINENCE**: Do you …

Usually have an urge to urinate before you leak urine? □ no □ yes

Leak urine or rush to the bathroom when you see/feel/hear running water? □ no □ yes

Leak urine or rush to the bathroom when you approach your home after being out? □ no □ yes

Leak urine when you cough, sneeze, laugh, or exercise? □ no □ yes

Wet the bed when you are completely asleep? □ no □ yes

Feel like you leak urine constantly? □ no □ yes

Wear pads to protect your clothing from leakage of urine? □ no □ yes

If you do wear pads: What kind? □ pantiliner □ thin pad □ thick pad □ diaper