Adult New Patient Medical Background Information

PATIENT INFORMATION

Patient Name: _____ Date of Birth _____/_____/_____

Chief Complaint: _____

MEDICATIONS (including prescription and over-the-counter)

1._____ 5._____

2._____ 6._____

3._____ 7._____

4._____ 8._____

Do you have any allergies to any medications? ❑ Yes ❑ No

If yes – please list:

_____

_____

PAST SURGICAL HISTORY

1._____ 5._____

2._____ 6._____

3._____ 7._____

4._____ 8._____

Have you ever had your tonsils and/or adenoids surgically removed? ❑ Yes ❑ No

SOCIAL HISTORY

Caffeine: _____ # of cups of coffee per day _____# of cups of tea per day

_____ # cans or glasses of soda per day _____# of servings of chocolate per week

_____# of energy drinks per day

Alcohol: ❑ None ❑ Yes _____ # of drinks per day _____ # of drinks per week _____ # of drinks per month

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Tobacco: ❑ None ❑ Yes _____ # of cigarette packs per day _____ # of years

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Recreational Drugs (such as marijuana or cocaine): ❑ None ❑ Yes

If yes, which ones? _____

Marital Status: ❑ Married ❑ Single ❑ Divorced ❑ Widowed

Children: ❑ No ❑ Yes How many? _____

Pets: ❑ No ❑ Yes How many? _____ **What type of pet**? _____

Do you have any children or pets that sleep in your bedroom? ❑ No ❑ Yes _____

REVIEW OF SYMPTOMS

Constitutional:

Loss of Appetite: ❑ Yes ❑ No

Sweats: ❑ Yes ❑ No

Fever: ❑ Yes ❑ No

Fatigue: ❑ Yes ❑ No

Weight Gain: ❑ Yes ❑No

Weight Loss: ❑ Yes ❑ No

Gastrointestinal:

GERD/Heartburn/Indigestion: ❑ Yes ❑ No

Black or Bloody Stools: Diarrhea: ❑ Yes ❑ No

Nausea/Vomiting: ❑ Yes ❑ No

Jaundice: ❑ Yes ❑ No

Abdominal Pain: ❑ Yes ❑ No

Respiratory:

Cough: ❑ Yes ❑ No

Asthma: ❑ Yes ❑ No

Wheezing: ❑ Yes ❑ No

Poor Exercise Tolerance: ❑ Yes ❑ No

Genitourinary:

Bed Wetting: ❑ Yes ❑ No

Frequent Urination: ❑ Yes ❑ No

Difficulty Urinating: ❑ Yes ❑ No

Blood in Urine: ❑ Yes ❑ No

Erectile dysfunction ❑ Yes ❑ No

REVIEW OF SYMPTOMS

Allergy/Immunology:

Sneezing: ❑ Yes ❑ No

Runny Nose: ❑ Yes ❑ No

Hives: ❑ Yes ❑ No

Itchy Eyes or Nose: ❑ Yes ❑ No

Nasal allergies/Hay fever: ❑ Yes ❑ No

Nasal Congestion: ❑ Yes ❑ No

Eyes:

Blurry Vision: ❑ Yes ❑ No

Double Vision: ❑ Yes ❑ No

Vision Loss: ❑ Yes ❑ No

Cardiac:

Palpitations: ❑ Yes ❑ No

Chest Pain: ❑ Yes ❑ No

Daytime Shortness of Breath: ❑ Yes ❑ No

Nighttime Shortness of Breath: ❑ Yes ❑ No

Ankle Swelling: ❑ Yes ❑ No

Skin:

Unusual Moles : ❑ Yes ❑ No

Rash: ❑ Yes ❑ No

Dryness: ❑ Yes ❑ No

Endocrine:

Heat Intolerance: ❑ Yes ❑ No

Excessive Thirst: ❑ Yes ❑ No

Constipation: ❑ Yes ❑ No

Cold Intolerance: ❑ Yes ❑ No

Cold Hands/Feet: ❑ Yes ❑ No

Decreased Libido: ❑ Yes ❑ No

Musculoskeletal:

Stiff/Sore Joints: ❑ Yes ❑ No

Muscle Pain: ❑ Yes ❑ No

Red or Swollen Joints: ❑ Yes ❑ No

Temporomandibular Joint (TMJ) pain/jaw discomfort: ❑ Yes ❑ No

Ears/Nose/Throat/Mouth:

Hearing Loss: ❑ Yes ❑ No

Sore Throat: ❑ Yes ❑ No

Sinus Congestion: ❑ Yes ❑ No

Hoarseness: ❑ Yes ❑ No

Neurologic:

Weakness: ❑ Yes ❑ No

Seizures: ❑ Yes ❑ No

Involuntary Tongue Biting: ❑ Yes ❑ No

Passing Out: ❑ Yes ❑ No

Dizziness: ❑ Yes ❑ No

Headaches: ❑ Yes ❑ No

Numbness: ❑ Yes ❑ No

Restless Leg Syndrome: ❑ Yes ❑ No

Psych:

Excessive Stress: ❑ Yes ❑ No

Memory Loss: ❑ Yes ❑ No

Difficulty with Focus: ❑ Yes ❑ No

Trouble Concentrating: ❑ Yes ❑ No

Hallucinations: ❑ Yes ❑ No

Nervousness or Anxiety: ❑ Yes ❑ No

Depressed Mood: ❑ Yes ❑ No

Medical History

Y N AIDS/HIV	**Y N** Chemotherapy	**Y N** Hepatitis	**Y N** Respiratory issues
Y N Anxiety	**Y N** Circulatory problems	**Y N** Hemophilia	**Y N** Recreational drugs
Y N Arthritis	**Y N** Dry mouth	**Y N** Herpes	**Y N** Thyroid issues
Y N ADD/ADHD	**Y N** Diabetes	**Y N** Insomnia	**Y N** Tobacco habit
Y N Artificial heart valve	**Y N** Depression	**Y N** Kidney problems	**Y N** Tuberculosis
Y N Asthma	**Y N** Emphysema	**Y N** Liver problems	**Y N** TMJ/TMD
Y N Artificial joints	**Y N** Epilepsy	**Y N** Mitral valve prolapse	**Y N** STD
Y N Allergies	**Y N** GERD/Acid Reflux	**Y N** Nervous problems	**Y N** Stroke
Y N Blood disease	**Y N** Heart problems	**Y N** Pace maker	**Y N** Shingles
Y N Back problems	**Y N** Headaches	**Y N** Pregnant (women)	**Y N** Ulcer/colitis
Y N Cancer	**Y N** Heart murmur	**Y N** Psychiatric care	**Other:**_____
Y N COPD	**Y N** High blood pressure	**Y N** Radiation treatment	_____

Please list all Medications: _____

_____

_____

Please list any Allergies: _____

_____

FAMILY HISTORY

Do you have a family history of any of the following medical illnesses? (Check if "yes" to all that apply):

- ❑ High blood pressure/hypertension
- ❑ Heart disease
- ❑ Stroke
- ❑ Congestive heart failure
- ❑ Depression
- ❑ Diabetes
- ❑ Overweight/obesity
- ❑ Snoring
- ❑ Sleep apnea
- ❑ Anxiety
- ❑ Chronic insomnia
- ❑ Restless legs syndrome
- ❑ Multiple sclerosis
- ❑ Sleep walking

THANK YOU FOR TAKING THE TIME TO COMPLETE THIS INFORMATION

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