# NEW PATIENT HEALTH INFORMATION FORM

**General/Constitutional**

| | | |
|---|---|---|
| Change in appetite | O Yes | O No |
| Chills | O Yes | O No |
| Fatigue | O Yes | O No |
| Fever | O Yes | O No |
| Headache | O Yes | O No |
| Lightheadedness | O Yes | O No |
| Sleep disturbance | O Yes | O No |
| Weight gain | O Yes | O No |
| Weight loss | O Yes | O No |

**ENT**

| | | |
|---|---|---|
| Difficulty swallowing | O Yes | O No |
| Nosebleed | O Yes | O No |
| Ringing in the ears | O Yes | O No |
| Sinus pain | O Yes | O No |
| Sore throat | O Yes | O No |

**Endocrine**

| | | |
|---|---|---|
| Cold intolerance | O Yes | O No |
| Excessive sweating | O Yes | O No |
| Excessive thirst | O Yes | O No |
| Frequent urination | O Yes | O No |
| Hair loss | O Yes | O No |
| Heat intolerance | O Yes | O No |
| Weakness | O Yes | O No |

**Respiratory**

| | | |
|---|---|---|
| Chest pain with breathing | O Yes | O No |
| Cough | O Yes | O No |
| Coughing up blood | O Yes | O No |
| Shortness of breath at rest | O Yes | O No |
| Shortness of breath with exertion | O Yes | O No |
| Sputum production | O Yes | O No |
| Wheezing | O Yes | O No |

**Cardiovascular**

| | | |
|---|---|---|
| Chest pain at rest | O Yes | O No |
| Chest pain with exertion | O Yes | O No |
| Difficulty lying flat | O Yes | O No |
| Dizziness | O Yes | O No |
| Fluid accumulation in the legs | O Yes | O No |
| Orthopnea | O Yes | O No |
| Palpitations | O Yes | O No |

**Gastrointestinal**

| | | |
|---|---|---|
| Abdominal pain | O Yes | O No |
| Blood in stool | O Yes | O No |
| Change in bowel habits | O Yes | O No |
| Constipation | O Yes | O No |
| Decreased appetite | O Yes | O No |
| Diarrhea | O Yes | O No |
| Heartburn | O Yes | O No |
| Hematemesis (vomiting blood) | O Yes | O No |
| Nausea | O Yes | O No |

PRINT NAME: _____DATE OF BIRTH: _____

PATIENT SIGNATURE: _____ DATE: _____

# NEW PATIENT HEALTH INFORMATION FORM

**Hematology**

| | | |
|---|---|---|
| Easy bruising | O Yes | O No |
| Prolonged bleeding | O Yes | O No |
| Recent transfusion | O Yes | O No |
| Swollen glands | O Yes | O No |

**Genitourinary**

| | | |
|---|---|---|
| Blood in urine | O Yes | O No |
| Difficulty urinating | O Yes | O No |
| Pain in lower back | O Yes | O No |
| Painful urination | O Yes | O No |

**Musculoskeletal**

| | | |
|---|---|---|
| Joint stiffness | O Yes | O No |
| Leg cramps | O Yes | O No |
| Muscle aches | O Yes | O No |
| Painful joints | O Yes | O No |

**Peripheral Vascular**

| | | |
|---|---|---|
| Cold extremities | O Yes | O No |
| Pain/cramping in legs after exertion | O Yes | O No |
| Ulceration of feet | O Yes | O No |

**Skin**

| | | |
|---|---|---|
| Blistering of skin | O Yes | O No |
| Discoloration | O Yes | O No |
| Rash | O Yes | O No |
| Sun sensitivity | O Yes | O No |

**Neurologic**

| | | |
|---|---|---|
| Memory loss | O Yes | O No |
| Seizures | O Yes | O No |
| Tingling/Numbness | O Yes | O No |
| Transient loss of vision | O Yes | O No |
| Tremor | O Yes | O No |

**Risk Factors: Coronary Artery Disease**

O High Blood Pressure
O Diabetes
O Smoking
O High Cholesterol
O Family history of Coronary Artery Disease
O Peripheral Vascular Disease

**Medications:** List Medications you are currently taking

_____

_____

_____

_____

**Allergies:** to medications or substances

_____

PRINT NAME: _____DATE OF BIRTH: _____

PATIENT SIGNATURE: _____ DATE: _____