

NEW PATIENT HISTORY FORM

NAME: \_\_\_\_\_ AGE: \_\_\_\_ DATE: \_\_\_\_\_ TIME: \_\_\_\_\_ am/pm

A. MAJOR SYMPTOMS

1. Tell us what are your **major symptoms** or problems for which you have come to us today and their duration.

B. TREATMENT RECEIVED

1. Number of physicians seen for the problems you have mentioned above, and their specialties:
  
  
  
  
  
  
  
  
  
  
2. Tell us about the **treatment you have received** for the problems you have mentioned above, such as investigations, and the tests that you had (including x-rays, CT scans, blood tests), and medicines used - prescription or over-the-counter medicines, etc.

3. Tell us about any **side effects** you may have had from the medicines or the treatment received for your problems (995.2).

\* 4. If you had any **allergy testing done in the past**, when was it done, who did it, and what was found?

\* 5. Did you receive any **allergy injections**, and if so, what symptoms got better, to what degree, and to what degree did it reduce the need for medicines?

C. **SYMPTOMS**

1. For women only:

<p><i>In this section, rate each of the following symptoms based upon your typical health profile.</i></p> <p><i>POINT SCALE</i></p> <p><i>0 = Never or almost never have the symptoms</i>  <i>1 = Occasionally have it, effect is not severe</i>  <i>2 = Occasionally have it, effect is severe</i>  <i>3 = Frequently have it, effect is not severe</i>  <i>4 = Frequently have it, effect is severe</i></p>	
<b>FEMALE REPRODUCTIVE SYSTEM</b>	
<p>_____ Ever had vaginal yeast infection (112.1)                  Total number of yeast infections in your lifetime: _____</p> <p>_____ Ever get any vaginal discharge at all (616.10)</p> <p>_____ Get premenstrual symptoms a few to several days before menses (625.4)</p> <p>What premenstrual symptoms (625.4) do you have:</p> <p>_____ premenstrual headaches                  _____ premenstrual depression                  _____ premenstrual irritability                  _____ premenstrual anxiety                  _____ premenstrual breast engorgement                  _____ premenstrual bloating                  _____ premenstrual fluid retention                  _____ other premenstrual symptoms: _____</p> <hr/> <p>_____ menstrual cramping (625.3)                  _____ pelvic pain (625.9)                  _____ vaginal pain (625.00)                  _____ breast pain (611.71) *</p> <p>Heavy menstrual bleeding (626.2)    Y    N                  Periods are irregular (626.4)        Y    N</p>	<p>Number of days you bleed _____ days                  How long is your cycle? (28, 30 days, etc.) _____                  Bleeding in-between menses (626.4) *    Y    N                  Headaches during menstruation    Y    N                  Menopausal                            Y    N                  Hot flashes, Night sweats, Vaginal dryness (encircle)                  Ever had miscarriage    Y    N    # _____                  _____ infertility                  _____ rectal itch</p> <p>Number of years you have taken <b>birth control pills</b>: _____                  Age when birth control pills first started: _____                  Are you currently on birth control pills:                            Yes    No                  Are you currently on female hormones: Yes                            No                  Number of years you have taken female hormones: _____                  Age when female hormones started: _____                  Age when <b>menses</b> started: _____ (years)                  When did you have last pap smear: _____                  By Dr. _____ Specialty: ___OB-GYN                  Other _____                  When did you have last mammogram? _____</p>

Info above reviewed

2. For Both Men and Women:

(i) \_\_\_\_\_ Have you ever taken **a lot of antibiotics** in your lifetime, including childhood: Yes No  
 Please note: Taking a lot of antibiotics is defined as: if you have ever taken antibiotics more than 2-3 times in a given year, or taken them continuously for a month for any condition, such as acne, urinary tract infection, sinus or bronchial infection, etc.

(ii) \_\_\_\_\_ Have you ever taken cortisone or cortisone-type medications such as prednisone in your lifetime, either as oral or by injection? Yes No  
 Please give details:

(iii) \_\_\_\_\_ Have you ever had rectal or jock itch? (110.3)

Number of times: \_\_\_\_\_

(iv) \_\_\_\_\_ Have you ever had athlete's foot? (110.4)

Number of times: \_\_\_\_\_

3. For both men and women:

<p><i>In this section, rate each of the following symptoms based upon your typical health profile.</i></p> <p><b>POINT SCALE</b></p> <p><i>0 = Never or almost never have the symptoms</i>  <i>1 = Occasionally have it, effect is not severe</i>  <i>2 = Occasionally have it, effect is severe</i>  <i>3 = Frequently have it, effect is not severe</i>  <i>4 = Frequently have it, effect is severe</i></p>	
<b>DIGESTIVE TRACT</b>	
<p>_____ Ever get constipated (564.0) *</p> <p>_____ Ever get diarrhea or loose stool (558.9) *</p> <p>_____ Alternating between constipation and diarrhea</p> <p>_____ Gas (787.3)</p> <p>_____ Belching (787.3)</p> <p>_____ Bloating in abdominal area (787.3)</p> <p>_____ Ever get abdominal pain (789.00)</p> <p>_____ Ever notice white, coated tongue (112.0)</p> <p>_____ Heartburn (787.1) *</p> <p>_____ Nausea (787.01)</p> <p>_____ Vomiting (787.03)</p>	<p>_____ Indigestion (536.8) *</p> <p>_____ Mucus in stool (792.1)</p> <p>_____ Bad Breath</p> <p>_____ Body Odor</p> <p>_____ Blood in stool (578.1)</p> <p>_____ Difficulty swallowing (787.2)</p> <p>_____ Poor appetite (783.0) *</p> <p>_____ Poor sense of taste</p> <p>_____ Get hungry a lot (783.6)</p> <p>_____ Excessive Thirst (783.5)</p> <p>_____ Hemorrhoids (455.6)</p>
<b>HEAD, EMOTIONS, AND MIND</b>	
<p>_____ Headaches (784.0) *</p> <p>_____ Migraine headaches (346.90)</p> <p>_____ Where does your head hurt: _____</p> <p>_____ Type of headache: throbbing – pressure, etc</p> <p>_____ What aggravates headaches: _____</p> <p>_____ Ever get depressed for no good reason (311)</p> <p>_____ Anxiety (300.0)*</p> <p>_____ Fear (799.2)</p> <p>_____ Nervousness (799.2)</p> <p>_____ Become irritable or angry easily (799.2)</p> <p>_____ Become aggressive easily (301.3)</p> <p>_____ "Fly-off-the-handle" (312.0)</p>	<p>_____ Reduction in memory (780.9)</p> <p>_____ Reduction in concentration (314.00)</p> <p>_____ Pressure in the head</p> <p>_____ Cannot think clearly</p> <p>_____ Mood swings (296.99)</p> <p>_____ Difficulty in making decisions</p> <p>_____ Confusion (298.9)</p> <p>_____ Poor comprehension</p> <p>_____ Learning difficulties or learning disabilities (315.2)</p> <p>_____ Hyperactivity (314.9)</p> <p>_____ Restlessness (799.2)</p> <p>_____ Insomnia (780.52) *</p> <p>_____ Drowsiness (780.09)</p>

Info above reviewed

In this section, rate each of the following symptoms based upon your typical health profile.

POINT SCALE

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ENERGY-ACTIVITY

<input type="checkbox"/> Get tired easily/fatigue/low level of energy * (780.79) <input type="checkbox"/> Get tired by the end of the day <input type="checkbox"/> Wake up tired <input type="checkbox"/> Sleep excessively (780.54) <input type="checkbox"/> Feel excessively cold at temperatures other people are comfortable in (780.9)	<input type="checkbox"/> Hypoglycemic symptoms if skip or delay meals (eg, weak, shaky, nervous, extremely uncomfortable) (251.2) ( <i>encircle which applies to you</i> ) <input type="checkbox"/> Weight Gain (783.1) * <input type="checkbox"/> Weight Loss (783.21) * <input type="checkbox"/> Underweight (783.22) <input type="checkbox"/> Muscular weakness or muscles tire easily
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SKIN

<input type="checkbox"/> Cold Hands <input type="checkbox"/> Cold Feet <input type="checkbox"/> Dry Skin (706.8) <input type="checkbox"/> Facial puffiness in the morning <input type="checkbox"/> Genital itch (698.1) <input type="checkbox"/> Genital rash <input type="checkbox"/> Hives (708.0) *	<input type="checkbox"/> Skin rashes (782.1)/Eczema (691.8) * <input type="checkbox"/> Psoriasis (696.1) * <input type="checkbox"/> Acne (706.1) <input type="checkbox"/> Excessive hair on body or face (704.1)*(for women) <input type="checkbox"/> Loss of scalp hair (704.00) * <input type="checkbox"/> Warts (078.10) <input type="checkbox"/> Excessive sweating (780.8)
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MUSCLES-JOINTS

<input type="checkbox"/> Ever get muscle aches/muscle pains/muscle spasms (728.85) * Where: arms (729.5); forearms, fingers (729.5); thighs (729.5); legs/feet (729.5); chest wall (786.52); flank (789.0); neck (723.1); generalized (780.9) ( <i>encircle which applies to you</i> ) <input type="checkbox"/> Muscle cramps/Charley horses (729.82) Where: upper extremity (729.82); lower extremity (729.82); other _____ <input type="checkbox"/> Leg cramping or leg pain on walking (443.9) <input type="checkbox"/> Low back pain/spasm (724.2) * <input type="checkbox"/> Pain or spasm/tightness, upper back (724.1)	<input type="checkbox"/> Pain or spasm, neck (723.1), shoulders, shoulder blades Specify the muscles that bother you:  <input type="checkbox"/> Arthritis joint pain (716.20) * Specify the joints that bother you: shoulders (719.41); elbows (719.42); wrists (719.43); hands (719.44); hips (719.45); knees (719.46); ankle & foot *(719.47); multiple joints (719.49); other joints:  <input type="checkbox"/> Carpal Tunnel Syndrome (350.00) * <input type="checkbox"/> Prolapsed Disc -- Neck, Back ( <i>encircle</i> ) <input type="checkbox"/> Any other painful condition: Explain _____  <input type="checkbox"/> Ever had X-rays of Joints      YES      NO Results:
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CARDIOVASCULAR

<input type="checkbox"/> High blood pressure (401.1) * <input type="checkbox"/> Rapid heartbeat (785.0) <input type="checkbox"/> Irregular or skipped heartbeat (427.9) <input type="checkbox"/> Palpitations (785.1) <input type="checkbox"/> Angina or chest pain (786.50) <input type="checkbox"/> Low blood pressure (458.9) * <input type="checkbox"/> Hands & feet get cold, blue, painful, swollen on exposure to cold (443.0) * ( <i>encircle</i> ) <input type="checkbox"/> Fluid Retention (276.6)	<input type="checkbox"/> Faintness/dizziness (780.4) * <input type="checkbox"/> Postural dizziness, ie, getting dizzy on standing abruptly (458.0) * <input type="checkbox"/> Salt cravings <input type="checkbox"/> Swelling ankles, feet, or hands (782.3) <input type="checkbox"/> Varicose veins (454.1) <input type="checkbox"/> High cholesterol/triglycerides * <input type="checkbox"/> Ever had echocardiogram, Stress test, EKG, Angiogram ( <i>encircle</i> ) Results:
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Info above reviewed

*In this section, rate each of the following symptoms based upon your typical health profile.*

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URINARY TRACT

<input type="checkbox"/> Ever had bladder, kidney, or urinary tract infection (595.2) Number of times you had an infection: _____ (595.2) Frequent urination (788.41)	<input type="checkbox"/> Burning on urination (788.1) <input type="checkbox"/> Awaken at night to urinate (788.43) <input type="checkbox"/> Urinate a lot (788.42) <input type="checkbox"/> Blood in urine (599.7)
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NOSE

<input type="checkbox"/> Stuffy nose (478.1) <input type="checkbox"/> Runny nose (478.1) <input type="checkbox"/> Sinus problem <input type="checkbox"/> Hay fever (477.0) When do you have the symptoms: spring, early summer, late summer, fall, spring through fall ( <i>encircle which applies</i> ) <input type="checkbox"/> Use nasal sprays: Yes No Name:	<input type="checkbox"/> Odor of freshly cut grass bothers <input type="checkbox"/> Nosebleeds (784.7) <input type="checkbox"/> Sneezing attacks (478.1) <input type="checkbox"/> Post-nasal drip (473.9) <input type="checkbox"/> Sinus pain (478.1) <input type="checkbox"/> Sinus infections (473.9) * <input type="checkbox"/> Ever had x-ray of sinuses YES NO Results:
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LUNGS

<input type="checkbox"/> Wheezing (786.07) <input type="checkbox"/> Asthma (493.0) * <input type="checkbox"/> Bronchitis (491.20) <input type="checkbox"/> Difficulty in breathing (786.09) <input type="checkbox"/> Coughing up blood	<input type="checkbox"/> Tightness in chest (786.59) <input type="checkbox"/> Chest congestion (514) <input type="checkbox"/> Shortness of breath (786.09) <input type="checkbox"/> Chronic cough (786.2) <input type="checkbox"/> Ever had chest x-ray YES NO Results:
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MOUTH, THROAT, & EARS

<input type="checkbox"/> Sore throat (784.1) <input type="checkbox"/> Hoarseness (784.49) <input type="checkbox"/> Loss of voice (784.41) <input type="checkbox"/> Canker sores (528.2) <input type="checkbox"/> Swollen or discolored tongue (529), gums, lips <input type="checkbox"/> Bad breath (784.9) <input type="checkbox"/> Motion sickness (994.6)	<input type="checkbox"/> Feeling of fluid in ears <input type="checkbox"/> Itching of ears/ear aches <input type="checkbox"/> Ear infection (382.4) <input type="checkbox"/> Drainage from ears (388.6) <input type="checkbox"/> Ringing in ears (388.32) <input type="checkbox"/> Hearing loss (389.9)
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EYES

<input type="checkbox"/> Watering (372.14)/itching of eyes (379.99) <input type="checkbox"/> Swollen, reddened, or sticky eyelids (373.00) <input type="checkbox"/> Bags or dark circles under the eyes	<input type="checkbox"/> Dry eyes (372.53) <input type="checkbox"/> Blurred vision (368.8) or tunnel vision (does not include near-sightedness or far-sightedness)
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When did you have your last physical exam: \_\_\_\_\_

By Doctor: \_\_\_\_\_ Specialty: \_\_\_\_\_

What was found and what was done:

Info above reviewed

D. SOCIAL AND ENVIRONMENTAL HISTORY

1	Do you <b>smoke?</b> How many years? _____	Y	N	11	What kind of <b>range (cooktop)</b> do you have: gas electric
	How many packs/day? _____			12	What kind of <b>dryer</b> do you have: gas electric
	Years in college: _____ Degree: _____			13	What kind of <b>heat</b> do you have in the house:
2	If so, do you have smoker's cough (491.0)	Y	N		Other: _____ gas electric
	Number of years smoked: _____			14	What kind of <b>water heater</b> do you have: gas electric
3	Do you <b>Chew Tobacco?</b>	Y	N	15	Age of your residence: _____ years
4	Tell us your habits regarding <b>drinking and drugs.</b>			16	Type: house apartment town house trailer
				17	Type of bed: Mattress Waterbed
5	Does <b>anyone smoke at home?</b>	Y	N	18	Is there dampness/mustiness in basement?
	Who does?			19	Humidifier: on furnace in bedroom
6	Do you get exposed to <b>smoke at work?</b>	Y	N	20	Ever had water leakage or damage in current house?
7	Tell us about your hobbies and recreations:			21	Exterminator use?
8	Do you have <b>dog?</b> Indoor Outdoor (encircle)	Y	N	22	Termite treatment of house?
9	Do you have <b>cat?</b> Indoor Outdoor (encircle)	Y	N	23	Use of weed killers/bug sprays on lawn?
10	Any <b>other pets?</b>				

24. Do any of the following smells bother you: yes no  
 Tobacco smoke (987.8), exhaust fumes (980.3), bleaches, detergents, soaps (989.6), ammonia, odor of new carpeting, asphalt, tar, moth balls, insect sprays, paints, varnishes, shellac, perfumes, hair sprays, cosmetics, gasoline products (980.3), natural gas, furniture polish, floor wax, rubbing alcohol (980.2), rubber, plastics, chlorinated water (987.6), newsprint, new fabric stores, spray cans, food odors, alcohol, formaldehyde, smoke from wood burning or fireplace, latex, odors of any kind:  
*(encircle the odors that bother you)*

Please explain in what way these odors bother you (987.8):

Do any of these smells or chemicals cause eye, ear, nose or throat symptoms (506.2)? Yes No  
 Do any of these smells or chemicals cause bronchial or chest symptoms (506.0)? Yes No  
 Do any of these smells or chemicals cause skin rashes (692.4)? Yes No

25. Are you exposed to any of these chemicals especially fragrances, cigarette smoke or pesticides at **work**: Yes No  
 If so, to which chemicals:

26. Are you exposed to any other chemicals including toxic chemicals, dusts, fumes, excessive humidity, mists, vapors, solvents, asbestos or gases: Yes No If so, please explain:

27. Are there any air polluting industries in your town or neighboring towns (refineries, mills, factories, etc.) Yes No  
 If yes, specify:

28. How is your sense of smell: average above average (781.1) below average (781.1) *(encircle one)*  
 How is your ability to detect leaking utility gas? Acute (781.1) Normal

29. Do foods bother you or disagree \* with you, including alcohol (980.0)? Yes No Explain:

30. Do you crave or over-consume sugar, bread, chocolate, colas, alcohol? Yes No *(encircle what applies to you)*

31. Do you get sleepy, tired, have runny nose, stuffy nose, indigestion, or any other symptoms after meals or after certain foods?  
 Yes No Explain:

32. Do you get alcohol hangovers (305.00)? Yes No Explain:

E. MEDICINES

1. List the medicines you are currently taking:

2. Are you **allergic** to any medicines (V14.9)? Yes No *(encircle your answer)*  
 Are you allergic to penicillin (V14.0); sulfa (V14.2); other antibiotics (V14.1); pain medicines (V14.6); anesthetics (V14.4) *(encircle which applies to you)*.  
 What other medicines are you allergic to (V14.8)? \_\_\_\_\_

Do any medicines cause skin rashes (693.0)? Yes No

Info above reviewed

F PAST SURGICAL HISTORY

1. Did you ever have **any surgery** such as tonsillectomy, adenoidectomy, tubes in the ears, sinus surgery, gall bladder, appendectomy, hysterectomy, ovaries removed, breast operations, hernia (encircle)?
2. Did you ever have any implants put in such as breast implants, dental implants, metal implants in joints such as knees, hips, etc., metal clips following abdominal surgery, dental fillings, root canals, etc. (encircle)
3. Other surgery: \_\_\_\_\_

G. MEDICAL:

1. Have you ever been diagnosed with any of the following (encircle what applies to you): hypothyroidism\* (low thyroid), goiter (enlarged thyroid), high cholesterol, \* high triglycerides, enlarged prostate (men), prostatitis (men), diabetes\*, hypoglycemia\*, bursitis (727.3)\*, tendonitis, arthritis, osteoporosis (733.02)\*, fibromyalgia (729.1)\*, mitral valve prolapse, heart murmur, coronary artery disease, heart disease, heart attack, Raynaud's disease \*, hiatal hernia, irritable bowel syndrome (564.1)\*, peptic ulcer, rectal or colon polyps, diverticulitis, gall stones, kidney or bladder stones, cancer, severe or life-threatening reactions to any food such as peanuts, other nuts, fish, shell fish, any drug or any other substance, allergy to stinging insects, especially wasp, honey bee, etc., alcoholism, whiplash injury to neck, gum diseases, bleeding gums, blood transfusion, abnormal pap smear (women), uterine fibroids (women), endometriosis (women) fibrocystic breast (women), abortions, miscarriages.
2. In your previous employments have you been exposed to: toxic chemicals, pesticides, weed killers, solvents, asbestos (encircle what applies to you).

H. INFECTIONS: Did you ever have any diseases such as chicken pox, measles, German measles, hepatitis, shingles, genital herpes, Lyme's Disease, tick bite, HIV, risk factors for HIV, fungal infections of skin or nails, pneumonia, tuberculosis (encircle)?

I. EFFECT OF ILLNESS

1. How many days out of the month are your **good days**, i.e., when you feel perfectly fine and nothing seems to bother you: \_\_\_\_\_ days out of 30 days
2. How many days out of the month are your **bad days**, i.e., when your symptoms bother you: \_\_\_\_\_ days out of 30 days
3. List your most bothersome symptoms here: \_\_\_\_\_ If you need more space, add additional page.
4. How are these symptoms bothersome for you, i.e. how are they interfering with your daily activities, family life, or career? If you need more space, add additional page.

**J. Preventive Care:** The following are preventive services. These are age oriented, which means not everyone needs everything listed below. The doctor will discuss with you on an individual basis what will be needed in your case. Please encircle what applies to you:

1. Received <b>flu vaccine</b> for this year: (V04.8)	No	Yes	Date: _____
2. Received <b>tetanus</b> and <b>diphtheria</b> (Td) injection: (V06.5)	No	Yes	Date: _____
3. Received <b>hepatitis</b> vaccine – a series of 3 injections: (V05.3)	No	Yes	Date: _____
4. Received <b>pneumovax</b> (pneumonia) injection: (V03.82)	No	Yes	Date: _____
5. <b>PSA</b> done (for men only – screen for prostate): (V76.44)	No	Yes	Date: _____
6. <b>Stool for occult blood</b> done (screen for colon cancer): (V76.41)	No	Yes	Date: _____
7. <b>Sigmoidoscopy</b> done (screen for colon cancer):	No	Yes	Date: _____
8. <b>HIV Blood Test</b>	No	Yes	Date: _____
9. Bone Density Studies	No	Yes	Date: _____

Info above reviewed

**K. FAMILY AND SOCIAL HISTORY**

1. Who lives at home besides you: \_\_\_\_\_  
 Number of children: \_\_\_\_\_ Age when 1<sup>st</sup> child born: \_\_\_\_\_ Age last child born: \_\_\_\_\_
2. Tell us about the health of your household (persons living at home besides the patient), i.e., are all of them in perfectly good health or have allergies (V19.6) or are prone to coughs, colds, bronchitis, wheezing, asthma (V17.5), hay fever (V17.6), ear infections, headaches, stomach aches, fatigue, or low level of energy, etc. Please provide the information below. Use additional page if needed.

**PERSONS LIVING AT HOME BESIDES THE PATIENT**

Name	Age	Relationship to the Patient	Any Health Problems? How bothersome are these problems on a scale of 0, 1, 2, 3, 4.
1.			
2.			
3.			
4.			
5.			
6.			

Are there any family members who have been treated, or are being treated at an environmental health or allergy center?

Yes No If yes, who is being, or has been, treated here? \_\_\_\_\_

Your occupation: \_\_\_\_\_ No. of years at current job: \_\_\_\_\_

Spouse's (husband or wife) occupation: \_\_\_\_\_

In the case of a **child**:

**Mother's** occupation: \_\_\_\_\_

**Father's** occupation: \_\_\_\_\_

**Parents'** marital status: \_\_\_\_\_

Tell us if anyone else in your **family** has: allergies (V19.6), asthma (V17.5), arthritis (V17.7), high blood pressure (V17.4), heart disease (heart attack, stroke, high cholesterol) (V17.4), diabetes (V18.0), breast cancer (V16.3), other cancer (V16.9), hypothyroid (low thyroid) (V18.1), depression, mental illness, or any other significant ailments in the family (encircle those appropriate).

**L. Thank You**

We thank you for giving us the opportunity to help you.

Were you referred to us by one of our patients? YES NO

If yes, whom may we thank for your referral: \_\_\_\_\_

The first step towards your recovery is . . .

Info above reviewed