New Patient History -PLEASE ANSWER AS BEST THAT YOU CAN **TODAY'S DATE: _____**

Patient Last Name	**First Name** **MI**	**Date of Birth**
Mother/Guardian: LIVING / DECEASED	**How many brother and sisters:** ___sisters ___ brothers Still Living?: ___yes ___no	
Father/Guardian: LIVING / DECEASED	**Your Occupation:**	**Who does the patient live with?**
Primary Care Physician/Pediatrician:	Other doctors involved with your care:	

REVIEW OF SYSTEMS

Has the patient ever been diagnosed with any of the following? If yes, please check any that apply and explain in the space provided; is your family physician aware of any symptoms/illnesses that you have checked below? Yes No

HISTORY	NO	YES	HISTORY	NO	YES	HISTORY	NO	YES	HISTORY	NO	YES
Birth Hx of Patient:			Cardiac			Neurological			Ear, Nose, & Throat		
Normal			High blood pressure			Seizures			Loose Teeth		
Premature			Low blood pressure			Weakness			Nosebleeds		
Cesarean			Irregular heartbeat			Migraines			Deafness		
Prematurity[A]			Chest pain			Previous stroke			Psychosocial		
Apnea/Bradycardia			Respiratory			Musculoskeletal			Alcoholism		
Intubations			Asthma			Muscle Disease			Substance Abuse		
BPD			Pneumonia			Arthritis			Depression		
ECMO			Bronchitis			Neck pain			Anxiety disorders		
Gastrointestinal			Chronic Cough			Back pain			Breast		
Diarrhea			Hoarseness			Blood Disorders			Lumps		
Constipation			Tracheotomy			Skin			Cancer		
Rectal Bleeding			Genitourinary			Rash			Please list below:		
Heartburn			Kidney Disease			Bruises			Any symptoms/diseases not listed above?		
Trouble swallowing			Frequent urine infection			Ophthalmic					
Nausea			Endocrine/Metabolic			Cataracts					
Vomiting			Diabetes			Glaucoma					
Abdominal Pain			Thyroid Disorders			Blindness					

PAST HISTORY

Please explain any YES answers in detailed description in the box provided.

Have you ever had any surgery or been Hospitalized? Have you had any problems with anesthesia? **IF SO, WHAT HAPPENED?**	O No O Yes	Surgeons	Dates	Hospitalizations other than Surgery	Dates
Are you currently, or have you ever used any tobacco or alcohol products?	O No O Yes	Alcohol: How many drinks O per day_____ O per week _____ O per month_____ Liquor: _____ Beer: _____			
Are you or have you ever used recreational /illicit drugs?	O No O Yes	If yes, what kind? For how long?			
Are you currently taking any medications, drugs, or vitamins? ***PLEASE ALSO ADD TO UNIVERSAL MEDICATION FORM***	O No O Yes	Medication	Dose	Times	Medication	Dose	Times
Do you have any allergies (including environmental, medication, food, and reaction to previous blood transfusion)?	O No O Yes **IF YES, PLEASE SPECIFY:**						

FAMILY HISTORY: Please indicate if your parents, brothers, sisters and/or children have had any of the following conditions:

Condition	Relation to patient	Condition	Relation to patient	Condition	Relation to patient
Colon/ Rectal Cancer No Yes		Kidney problems No Yes		Heart Disease No Yes	
Stomach Cancer No Yes		Ulcerative Colitis No Yes		Crohn's Disease No Yes	
Breast Cancer No Yes		Ovarian Cancer No Yes		Bleeding Problems No Yes	

Person Completing This Form: _____ **Reviewed by Provider: _____** **Date: _____**