NEW PATIENT MEDICAL HISTORY

	Last name	First Name	Birthdate	native Language
Full Name, Birthdate				
Address				
E-Mail				
Phone/mobile number				

PRESENT SYMPTOMS (briefly)	

OTHER PRACTITIONERS Providers/Specialists	Specialist	Name	Last visit

CURRENT MEDICATIONS Any that you are now taking. Name of drug	Morning	Midday	Evening	Night
Drug allergies / to what?				
Other allergies / to what?				

SYSTEMS REVIEW In the past month, have you had any of these problems?		Recent weight change		Weakness		Fever
		Joint pain/swelling		Muscle weakness		Numbness
		Ears ringing/hearing loss		Eyes/vision disorders		Throat/hoarseness)
		Heart pain/palpitations/edema		Fainting/Breath		Lungs/Cough/Sputum
		Nervous system/headache		Dizziness/Memory		Psychiatric/Depression
		Skin/redness/rash/hair loss		Blood/Anemia/Clots		Kidney / Urine /
		Women/reproductive disorders		Stomach pain/nausea		Jaundice/black stools
		Vomiting/heartburn		Diarrhea/Constipation		
Other problems:						

PAST MEDICAL HISTORY Do you now or have you ever had:		Diabetes mellitus		High blood pressure		High cholesterol
		Hypothyroidism/Goiter		Cancer/type:		Leukemia
		Psoriasis		Angina pectoris		Heart problems
	Heart murmur		Pneumonia		Pulmonary embolism		Asthma
	Emphysema		Stroke		Epilepsy (seizures)		Cataracts
	Kidney disease		Kidney stones		Crohn's disease		Colitis
	Anemia		Jaundice		Hepatitis		Stomach/peptic ulcer
	Rheumatic fever		Tuberculosis		HIV/Aids		Migraine

FAMILY HISTORY							
	High Blood Pressure		Asthma		Emphysema /COPD		Early Death
	Heart Disease		High Cholesterol		Kidney Disease		Migraines

SOCIAL HISTORY	Occupation:	Retired/Unemployed/LOA/Disabled?	Night shift?
Do you have children?	Marital status: -Single- / -Partner- / -Married- / -Divorced- /- Widowed- / -Other-:		

OTHER HEALTH ISSUES							
Do you drink alcohol?	NO	Beer / Wine / Liquor		Drinks/day:		Past: YES	Quit Date:
Smoke Cigarettes?	NO	# /day:		# of Years:		Past: YES	Quit Date:
Drug use?	NO	Stimulants	Cannabis	Sedatives	Inhalants	Heroin	Hallucinogens
Exercise regularly?	NO	What kind of exercise?			Duration:		How often:
Sleep	How many hours, on average, do you sleep per day?						
Diet	How would you rate your diet?		Good	Fair	Poor	Would you like advice on your diet? -Y- / -N-	
Body weight	kg		Height	cm		Date:	
Do you have vaccination certificates?		NO	Last Tetanus Booster or TdaP:			Flu Vaccine:	
Colonoscopy	Date:		Result:				

Reminder/ Callback allowed	NO	Phone:	Mobile:	eMail:

Declaration and declaration of consent

I agree that my data is electronically saved and edited. ❑ Yes ❑ No

I agree that my attending physician may request treatment data and findings from other physicians or therapists.
I understand that I can withdraw this consent at any time.

I agree that my treating physician may submit my treatment data and medical findings to other physicians and therapists for treatment purposes.
I understand that I can withdraw this consent at any time.

With my signature, I confirm the completeness and accuracy of my information and that I have read and understood the printed information

_____

Place, Date, Signature (Patient/Guardian)