THE VILLAGE DOCTOR NEW PATIENT HISTORY

Last Name **First** **Middle Initial** **Birth Date** **Age**

Address **City** **State** **Zip Code**

Home Phone **Work Phone** **Cell Phone**

Email **Social Security #**

Occupation **Employer**

FEMALES ONLY: Are you pregnant? □ Yes □ No

ILLNESS/INJURY: Please check if you have ever had any of the following

Yes	No		Yes	No	
		High blood pressure			Kidney stones
		Diabetes			Abdominal bleeding
		Peptic ulcers			Diverticulosis
		Heart attack			Thyroid problem
		Chest pain/tightness			Lung problems/asthma
		History of heart murmur			Shortness of breath
		Stroke			Seizures
		Cancer			Depression
		Hepatitis			High Cholesterol
		Yellow jaundice			Arthritis
		Gallstones			Cataracts

Surgeries (including childbirth)

Year	Name of operation	Type of anesthetic, if known	Complications

MEDICATIONS: Please list all medications you take and their dosages ***(continue on reverse side if necessary***

Drug	Dosage	Drug	Dosage

Have you ever had a blood transfusion? ( ) No Yes ( ) If yes, when_____

Please list medical conditions not listed above:

ALLERGIES: Please list type and reaction □ No known allergies

Drug	Reaction	Drug	Reaction

Marital status: □ Single □ Married (how long? _____) □ Separated □ Divorced (how long? _____)
□ Widowed (how long?_____) Number of others in home_____

History

Significant birth events:_____

Premature birth? □ Yes □ No

List all injuries (continue on the reverse side if necessary):

Injuries *Date(s)*

_____

_____

_____

_____

List any other medical conditions you have had (do not include common cold or flu):

Illnesses *Date(s)*

_____

_____

_____

_____

How often do you get a cold? _____

If your family has a history of any of these conditions, please do the following:

a. Circle the condition

b. Write 'F' for father, 'M' for mother, or 'S' for sibling within the parentheses

( ) Heart disease ( ) Kidney problems ( ) Stroke
( ) Cancer ( ) High blood pressure ( ) Diabetes
( ) Obesity ( ) Depression ( ) Schizophrenia
( ) Early senility ( ) Manic-depressive disorder ( ) Other (please list on the reverse side)
( ) Seizure disorder ( ) Alcoholism ( ) Migraines

Father ( ) Alive Age_____ ( ) Deceased at age_____ Cause of death:_____

Mother ( ) Alive Age_____ ( ) Deceased at age_____ Cause of death:_____

Initials_____

List all supplements/alternative remedies (vitamins, minerals, herbs, etc.) you are currently taking and/or alternative treatments you are undergoing (continue on reverse if necessary):

Supplement/Alternative treatment *Size (mg, mcg, etc.)* *Daily dose*

List any handicaps or impairments (such as vision or hearing loss):

Review of systems

Are you **currently** experiencing any of these symptoms?

Y N		Y N	
	1. Constitutional		**7. Genito-Urinary**
□ □	Recent fever	□ □	Blood in urine
□ □	Recent weight loss	□ □	Painful/burning urination
□ □	Fatigue	□ □	Frequent urination
	2. Eyes		**8. Musculoskeletal**
□ □	Glaucoma	□ □	Frequent fractures or sprains
□ □	Recent changes in vision	□ □	History of arthritis
	3. Ears, Nose, Mouth, Throat		**9. Skin**
□ □	Frequent ear infections	□ □	Recent changes in skin
□ □	Ringing in the ears	□ □	Rash or itching
□ □	Earaches or drainage	□ □	Change in hair or nails
□ □	Frequent sore throats		**10. Neurological**
□ □	Frequent sinus infections	□ □	History of frequent headaches
□ □	Nose bleeds	□ □	Numbness or tingling sensation
□ □	**4. Cardiovascular**	□ □	Seizures or convulsions
□ □	Sudden heartbeat changes	□ □	Tremors
□ □	Swelling of feet, ankles, hands	□ □	Paralysis
□ □	Chest pains or discomfort in chest		**11. Psychiatric**
□ □	Shortness of breath	□ □	Treatment for psychiatric problems
	5. Respiratory (*circle those that apply*)	□ □	Treatment for drug or alcohol dependency
□ □	Frequent coughing	□ □	Sleep problems
□ □	Spitting up blood	□ □	Memory loss or confusion
□ □	Wheezing	□ □	Nervousness/Depression
□ □	Asthma, bronchitis, pneumonia, pleurisy, TB		**12. Endocrine**
	6. Gastrointestinal	□ □	Decreased energy
□ □	Frequent indigestion or heartburn	□ □	Dizziness
□ □	Vomiting		**13. Hematologic/Lymphatic**
□ □	Passing bloody or black stools	□ □	Easy bruising or bleeding
□ □	Stomach pain	□ □	Swollen glands
□ □	Loss of appetite	□ □	Slow to heal after cuts
			14. Allergic/Immunologic
		□ □	Severe allergic reactions to:
		□ □	Hay fever

Social history

Y N	
□ □	Do you smoke now? ___Cigarettes ___Cigars ___Pipe How many per day?
□ □	Have you smoked in the past? (Year quit:)
□ □	Do you drink alcohol now? If yes how much per day?
□ □	Did you drink alcohol in the past?
□ □	Do you currently use street drugs?
□ □	Have you used street drugs in the past?

Signature of person completing the form: □ Patient □ Other _____ **Date**