

NEW PATIENT HISTORY FORM

Name: _____ Birth date: _____

DATE OF APPOINTMENT: _____

WHAT PROVIDER ARE YOU SEEING? Dr. Mary Arenberg _____
Dr. George Schroeder _____

PAST MEDICAL HISTORY (please list year if possible)

Any unusual childhood illnesses:

Past hospitalizations and surgeries:

Medical Problems:

CURRENT MEDICATIONS (please list both prescription and non-prescription):

MEDICATION ALLERGIES AND TYPE OF REACTION: _____

Do you have a history of Latex sensitivity or allergy? Yes No

Do you or any family member have problems with anesthesia? Yes No

Do you or any family member have bleeding problems? Yes No

PERSONAL HISTORY

Marital status: married___ single___ divorced___ widow___

Your occupation: _____

Last year of school completed: _____

Tobacco use: yes___ no___

If yes what age did you start? _____

If yes how many packs per day? _____

Do you use chewing tobacco? Yes No

Alcohol use:

How many days per week do you drink alcohol? _____

How many drinks per day? _____

Other drug use? _____

FAMILY HISTORY (Please list any illness in your family members such as heart disease, stroke, diabetes, cancer, high blood pressure, high cholesterol, lung disease, liver or kidney disease, depression or suicide)

Father: _____

Mother: _____

Brothers or sisters: _____

Paternal grandfather: _____

Paternal grandmother: _____

Maternal grandfather: _____

Maternal grandmother: _____

Please list your children and any health problems they have: _____

Please check any problems listed below that you have had in the last year:

- Fever, chills, night sweats, weight loss or gain
- Headaches, head injuries, concussion
- Eye problems, do you wear contacts or glasses?
- Do you have any loose or capped teeth? Dentures?
- Cold or allergy symptoms, nose bleeds
- Ear problems, hearing loss, ringing, ear pain
- Thyroid problems or x-ray treatment to neck or chest
- Breast masses, breast discharge, breast pain
- Breathing problems, shortness of breath, asthma, bronchitis, pneumonia, emphysema
- High blood pressure, rheumatic fever, chest pain, palpitations or skipped beats, heart murmur
- Heartburn, ulcers, gallstones, constipation, diarrhea, bloody or black bowel movements, abdominal pain
- Kidney or bladder infection, leaking urine, pain with urination, kidney stones
- Muscle pain, joint pain or swelling, broken bones, dislocations, muscle weakness
- Seizure, loss of coordination, tremors, speech problems, memory loss, numbness, tingling
- Rash, mole change, skin infections, hair loss
- Abnormal bleeding from any site, clotting problems, bruising easily
Have you ever had any blood transfusions? _____
- Depression, poor sleeping, appetite problems, panic attacks, suicidal thoughts or attempts
- Concerns about sexuality or sexual function?

___ Females age 16 – 55: what was the date of your last menstrual period?

ANY ADDITIONAL CONCERNS YOU WOULD LIKE TO ADDRESS TODAY?