

# 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?

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