



**NEW PATIENT MEDICAL HISTORY**

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Today's Date \_\_\_\_\_

Who referred you to us? \_\_\_\_\_

Primary Care Provider: \_\_\_\_\_

Reason for Today's Visit: \_\_\_\_\_

Preferred Pharmacy: \_\_\_\_\_

Allergies: \_\_\_\_\_

**Past Medical History (please check all that apply)**

- |  |  |
|--|--|
| <input type="checkbox"/> Type 1 Diabetes             | <input type="checkbox"/> Pacemaker / Defibrillator   |
| <input type="checkbox"/> Type 2 Diabetes             | <input type="checkbox"/> Blood Clots – Where? _____  |
| <input type="checkbox"/> Neuropathy                  | <input type="checkbox"/> Stroke                      |
| <input type="checkbox"/> Peripheral Vascular Disease | <input type="checkbox"/> HIV / AIDS                  |
| <input type="checkbox"/> Venous Disease/Stasis       | <input type="checkbox"/> Hepatitis- What kind? _____ |
| <input type="checkbox"/> Lymphedema                  | <input type="checkbox"/> Asthma                      |
| <input type="checkbox"/> Lupus                       | <input type="checkbox"/> COPD                        |
| <input type="checkbox"/> Kidney Disease              | <input type="checkbox"/> Seizures                    |
| <input type="checkbox"/> High Blood Pressure         | <input type="checkbox"/> Cancer- What kind? _____    |
| <input type="checkbox"/> High Cholesterol            | <input type="checkbox"/> Thyroid Disease             |
| <input type="checkbox"/> Coronary Artery Disease     | <input type="checkbox"/> Anxiety                     |
| <input type="checkbox"/> Heart Attack                | <input type="checkbox"/> Depression                  |
| <input type="checkbox"/> Congestive Heart Failure    | <input type="checkbox"/> Other: _____                |
| <input type="checkbox"/> Atrial Fibrillation         | <input type="checkbox"/> _____                       |
| <input type="checkbox"/> Pacemaker / Defibrillator   |  |

## Surgical History

Name of Surgery	Date of Surgery	Surgeon

## Family History (check all that apply)

Conditions:	Mother	Father	Maternal Grandparent	Paternal Grandparent	Sibling	Child
Diabetes						
Heart Disease						
High Blood Pressure						
Lupus						
Kidney Disease						
Lung Disease						
Unknown History						

## Social History:

Are you married, single, divorced or separated? \_\_\_\_\_

Who lives at home with you? \_\_\_\_\_

Are you currently employed? \_\_\_\_\_ If so, what do you do for work? \_\_\_\_\_

Do you use tobacco products? \_\_\_\_\_ What kind of tobacco? \_\_\_\_\_

How many cigarettes per day? \_\_\_\_\_ How long have you used tobacco? \_\_\_\_\_

If you quit using tobacco, when did you quit? \_\_\_\_\_

Do you drink alcohol? \_\_\_\_\_ How many drinks per day? \_\_\_\_\_

Do you use any drugs? If so, which ones? \_\_\_\_\_

Do you have home health? If so, which company? \_\_\_\_\_

## Review of Systems

Please check any symptoms that you are **currently experiencing** or have experienced in the **last 2 weeks**.

<p><b>Constitutional:</b></p> <ul style="list-style-type: none"><li><input type="checkbox"/> Chills</li><li><input type="checkbox"/> Fever</li><li><input type="checkbox"/> Fatigue</li><li><input type="checkbox"/> Weight Changes</li><li><input type="checkbox"/> Glasses/Contacts</li><li><input type="checkbox"/> Vision Changes</li></ul> <p><b>Respiratory:</b></p> <ul style="list-style-type: none"><li><input type="checkbox"/> Cough</li><li><input type="checkbox"/> Shortness of Breath</li><li><input type="checkbox"/> Oxygen Use</li></ul> <p><b>Cardiac:</b></p> <ul style="list-style-type: none"><li><input type="checkbox"/> Chest Pain</li><li><input type="checkbox"/> Palpitations</li><li><input type="checkbox"/> Leg pain at rest</li><li><input type="checkbox"/> Leg pain with activity</li><li><input type="checkbox"/> Swelling in legs</li><li><input type="checkbox"/> Difficulty breathing when lying flat</li></ul> <p><b>GI:</b></p> <ul style="list-style-type: none"><li><input type="checkbox"/> Nausea</li><li><input type="checkbox"/> Vomiting</li><li><input type="checkbox"/> Diarrhea</li><li><input type="checkbox"/> Abdominal Pain</li><li><input type="checkbox"/> Trouble Swallowing</li></ul>	<p><b>Skin:</b></p> <ul style="list-style-type: none"><li><input type="checkbox"/> Rash</li><li><input type="checkbox"/> Changes in skin color</li><li><input type="checkbox"/> Ulcers</li><li><input type="checkbox"/> Prone to skin tears</li><li><input type="checkbox"/> Calluses / Corns</li><li><input type="checkbox"/> Changes in hair/skin/nails.</li></ul> <p><b>Musculoskeletal:</b></p> <ul style="list-style-type: none"><li><input type="checkbox"/> Decreased activity level</li><li><input type="checkbox"/> Use of a walker / cane / wheelchair</li></ul> <p><b>Neurological:</b></p> <ul style="list-style-type: none"><li><input type="checkbox"/> Abnormal Gait</li><li><input type="checkbox"/> Numbness</li><li><input type="checkbox"/> Tingling</li><li><input type="checkbox"/> Pain from Neuropathy</li><li><input type="checkbox"/> Paralysis</li><li><input type="checkbox"/> Weakness</li><li><input type="checkbox"/> Seizures</li></ul> <p><b>Psychiatric:</b></p> <ul style="list-style-type: none"><li><input type="checkbox"/> Anxiety</li><li><input type="checkbox"/> Depression</li><li><input type="checkbox"/> Claustrophobia</li><li><input type="checkbox"/> Suicidal thoughts</li></ul> <p><b>Hematologic:</b></p> <ul style="list-style-type: none"><li><input type="checkbox"/> Problems with bleeding or clotting</li><li><input type="checkbox"/> Easy bruising</li><li><input type="checkbox"/> Taking a blood thinner</li></ul>
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**History of Current Wound(s):**

What caused your wound? \_\_\_\_\_

How long have you had it? \_\_\_\_\_

What have you treated it with? \_\_\_\_\_

Are you currently taking antibiotics for your wound? \_\_\_\_\_

Have you had a recent X-ray, MRI, or cat scan for the wound? \_\_\_\_\_

When & Where? \_\_\_\_\_

What did it show? \_\_\_\_\_

What other things have you done (if anything) to help make the wound better?

\_\_\_\_\_

**Please list all your medications, dosages, and how you take them:**

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Do you agree to participate in medication history retrieval if we need to request information from your pharmacy? Yes \_\_\_\_\_ No \_\_\_\_\_