New Patient Form

Today's Date:
Patient Name:
Preferred Name:
Please Circle One:
Married
Single
Child
Other
Gender:
Male
Female
Other
Patient Address:
City:
Zip:
State:
County:
Home phone:
Work phone:
Cell phone:
Would you like to receive appointment reminders via text message?
Yes
No
Would you like to receive appointment reminders via email?
Yes
No
Email address
Patient Employer:
Occupation:
Choose One Two Three
Whom can we thank for refferring you to our office?
In case of an emergency, whom shall we call?
Name:
Relationship:
Phone:
(If the patient is a minor) Name of Parent or Responsible Party:
Parent Date of Birth:
Patient Address:
City:
State:
Zip code:
Health History
Do you have or have you ever had any of the following? Please check all (YES or NO) that apply:
AIDS/HIV
Yes
No
Artificial Joints

Yes

No Bloody Sputum Yes No Bisphosphonate Medication Yes No Chronic Cough, >3 weeks Yes No Epilepsy Yes No Fainting Yes No Growths Yes No High Blood Pressure Yes No
Yes No Bisphosphonate Medication Yes No Chronic Cough, >3 weeks Yes No Epilepsy Yes No Fainting Yes No Growths Yes No High Blood Pressure Yes
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No Chronic Cough, >3 weeks Yes No Epilepsy Yes No Fainting Yes No Growths Yes No High Blood Pressure Yes
Chronic Cough, >3 weeks Yes No Epilepsy Yes No Fainting Yes No Growths Yes No High Blood Pressure Yes
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Epilepsy Yes No Fainting Yes No Growths Yes No High Blood Pressure Yes
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No Fainting Yes No Growths Yes No High Blood Pressure Yes
Fainting Yes No Growths Yes No High Blood Pressure Yes
Yes No Growths Yes No High Blood Pressure Yes
No Growths Yes No High Blood Pressure Yes
Growths Yes No High Blood Pressure Yes
Yes No High Blood Pressure Yes
No High Blood Pressure Yes
No High Blood Pressure Yes
Yes
Heart Murmur
Yes

No

Yes No

Yes No

Yes No

Yes No

Yes No

Yes No

Jaundice

Loss Appetite

Mitral Valve Prolapse

Nervous Disorders

Prosthetic Heart Valve

Hyper Thyroid

Sexually Transmitted Diseases
Yes
No
Unexplained Weight loss
Yes
No No
Anemia
Yes
No No
Asthma
Yes
No No
Brast implants
Yes
No No
Cancer
Yes
No
Growths
Yes
No
Diabetes
Yes
No .
Emphysema
Yes
No.
Fatigue
Yes
No
Hay Fever
Yes
No .
Hemoptysis
Yes
No .
Hepatitis Programme Transfer of the Control of the

Respiratory Problems

Stomach Problems Ulcers

Yes No

Yes No

Yes No
Mental Disorders
Yes
No
Night Sweats
Yes No
Pacemaker
Yes
No No
Rheumatic Fever
Yes
No Fadiation Treatment
Yes Yes
No No
Sinus Probmes
Yes
No
Tuberculosis
Yes No
Other:
Yes
No
Arthritis
Yes No
Blood Disease
Yes
No No
Blood Thinners
Yes No
Chest Pain
Yes

Yes No

Yes No

Hypo Thyroid

Kidney Disease

Excessive Bleeding Yes No Glaucoma Yes No Head Injury Yes No Heart Disease Yes No Horaseness Yes No Liver Disease Yes No Recent Surgery Yes No Stroke Yes No Transplant Yes No Tumors	No				
Excessive Bleeding Yes No Glaucoma Yes No Head Injury Yes No Heart Disease Yes No Horaseness Yes No Liver Disease Yes No Recent Surgery Yes No Stroke Yes No Transplant Yes No Tumors	Dizzine	ss			
Yes No Horaseness Yes No High Cholesterol Yes No Liver Disease Yes No Recent Surgery Yes No Stroke Yes No Transplant Yes No Tumors	Yes				
Yes No Glaucoma Yes No Head Injury Yes No Heart Disease Yes No Horaseness Yes No Liver Disease Yes No Recent Surgery Yes No Stroke Yes No Transplant Yes No Trumors	No				
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Yes No Liver Disease Yes No Recent Surgery Yes No Stroke Yes No Transplant Yes No Tumors	No				
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Liver Disease Yes No Recent Surgery Yes No Stroke Yes No Transplant Yes No Tumors Yes	Yes				
Yes No Recent Surgery Yes No Stroke Yes No Transplant Yes No Tumors	No				
Recent Surgery Yes No Stroke Yes No Transplant Yes No Tumors Yes No	Liver Di	isease			
Recent Surgery Yes No Stroke Yes No Transplant Yes No Tumors Yes No	Yes				
Recent Surgery Yes No Stroke Yes No Transplant Yes No Tumors Yes No Previous	No				
Stroke Yes No Transplant Yes No Tumors Yes	Recent	Surgery			
Stroke Yes No Transplant Yes No Tumors Yes	Yes				
Yes No Transplant Yes No Tumors Yes	No				
Transplant Yes No Tumors Yes	Stroke				
Transplant Yes No Tumors Yes					
Yes No Tumors Yes No	No				
No Tumors Yes No	Transpl	ant			
Tumors Yes No					
Yes No	No				
No	Tumors	;			
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