



# NEW PATIENT HISTORY

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ MALE / FEMALE Date \_\_\_\_\_

Occupation: \_\_\_\_\_

Left handed or Right handed

Marital Status: Single Married Divorced Widowed

Children? Y or N # \_\_\_\_\_

Previous Treating Physician: \_\_\_\_\_

Last Visit \_\_\_\_\_

Current Problem: \_\_\_\_\_

Date problem began: \_\_\_\_\_

Other treating physicians: \_\_\_\_\_

Are you allergic to any medications? YES NO \_\_\_\_\_

Have you ever been hospitalized? YES NO Date: \_\_\_\_\_ Reason: \_\_\_\_\_

Date: \_\_\_\_\_ Reason: \_\_\_\_\_

Previous surgeries: YES NO Date: \_\_\_\_\_ Surgeries: \_\_\_\_\_

Date: \_\_\_\_\_ Surgeries: \_\_\_\_\_

Date: \_\_\_\_\_ Surgeries: \_\_\_\_\_

Any issues with anesthesia YES NO Issue: \_\_\_\_\_ Latex Allergy: YES NO

### Have you had any of the following?

- Colonoscopy  No  Yes Date: \_\_\_\_\_
- Lab Work  No  Yes Date: \_\_\_\_\_
- Flu Vaccine  No  Yes Date: \_\_\_\_\_
- Tetanus Vaccine  No  Yes Date: \_\_\_\_\_
- Stress Test  No  Yes Date: \_\_\_\_\_
- EKG  No  Yes Date: \_\_\_\_\_
- Heart Cath  No  Yes Date: \_\_\_\_\_
- Bone Density  No  Yes Date: \_\_\_\_\_

### Was service provided at a Memorial Hermann Facility? If no, list facility

- Provider: \_\_\_\_\_ MH Facility Y N \_\_\_\_\_
- Provider: \_\_\_\_\_ MH Facility Y N \_\_\_\_\_
- Provider: \_\_\_\_\_ MH Facility Y N \_\_\_\_\_
- Provider: \_\_\_\_\_ MH Facility Y N \_\_\_\_\_
- Provider: \_\_\_\_\_ MH Facility Y N \_\_\_\_\_
- Provider: \_\_\_\_\_ MH Facility Y N \_\_\_\_\_
- Provider: \_\_\_\_\_ MH Facility Y N \_\_\_\_\_
- Provider: \_\_\_\_\_ MH Facility Y N \_\_\_\_\_

### WOMEN:

- Are you still having monthly menstrual periods? YES NO
- Age periods began \_\_\_\_\_
- Number of live births # \_\_\_\_\_
- Have you had a Hysterectomy? YES NO
- Do you take birth control now? YES NO
- Mammogram YES NO
- Date: \_\_\_\_\_
- Do you bleed between periods? YES NO

- Date of last period \_\_\_\_\_
- Have you had any miscarriages? YES NO # \_\_\_\_\_
- Have you had any abortions? YES NO # \_\_\_\_\_
- Have you ever had nipple discharge? YES NO
- Have you ever had a breast lump? YES NO
- Did you take birth control pill previously? YES NO
- Pap Smear YES NO
- Date: \_\_\_\_\_

### HABITS

- Tobacco Use  No  Yes Type and Amount per Day \_\_\_\_\_ Age started smoking: \_\_\_\_\_
- Alcohol Use  No  Yes Type and Frequency \_\_\_\_\_
- Drug Use  No  Yes Type and Frequency \_\_\_\_\_
- Caffeine Use  No  Yes Type and Frequency \_\_\_\_\_
- Exercise  No  Yes Type and Frequency \_\_\_\_\_
- Sun Exposure  No  Yes Type and Frequency \_\_\_\_\_
- Wear Seatbelt  No  Yes Type and Frequency \_\_\_\_\_

Patient Name:

Date of Birth:

Please review the items below and indicate if you or your family has or has had any of the problems listed. Write the letter of the person who has had the issue in the box next to the problem.

(X) Self (M) Mother (F) Father (G) Grandparent (B) Brother (S) Sister

GENERAL		PULMONARY/LUNG		MUSCULOSKELETAL		NEUROLOGICAL	
Alcoholism		Asthma		Arthritis		Alzheimer's	
Chills		COPD		Atrophy		Brain Tumor	
Fatigue		Coughing		Back pain		Dizziness	
Fever		Coughing up blood		Cramps		Epilepsy	
Glaucoma		Emphysema		Deformity		Fainting spells	
Night sweats		Lung disease		Fibromyalgia		Headaches	
Poor appetite		Pneumonia		Limited motion		Hearing issues	
Weakness		Pulmonary embolism		Locking/catching		Un-consciousness	
Weight gain		Shortness of breath		Loss of limb		Palsy	
Weight loss		Tuberculosis		Lupus		Paralysis	
<b>CARDIOVASCULAR</b>		Wheezing		Mass		Parkinson	
Chest pain (angina)		<b>GENITOURINARY</b>		Muscular disorder		Seizures	
Congestive heart failure		Blood in urine		Numbness		Stroke	
Coronary artery disease		Frequent urination		Osteoporosis		T.I.A.	
Elevated cholesterol		Kidney disease		Pain		<b>BLOOD</b>	
Heart Attack		Kidney stone pain		Popping		Aids/HIV	
Heart Murmur		Wake up to urinate		Psoriasis		Anemia	
High blood pressure		Painful urination		Redness		Bleeding Disorder	
Irregular heartbeat		Discharge		Stiffness		Blood Transfusion	
Low blood pressure		Prostate		Swelling		Leukemia	
Pacemaker		Urgent urination		Tingling		Sickle Cell	
Palpitations		<b>HEAD/EARS/NOSE/THROAT</b>		Weakness		<b>GASTROINTESTINAL</b>	
Phlebitis/clots in legs		Hay fever		<b>PSYCHIATRIC</b>		Abdominal pain	
Rheumatic fever		Hoarseness		Anxiety		Black stools	
Shortness of breath		Neck stiffness/pain		Depression		Constipation	
Swelling of feet		Nose bleeds		Psychiatric treatment		Diarrhea	
Swollen ankles		Postnasal drip		Schizophrenia		Gas	
<b>SKIN</b>		Visual problems		<b>LYMPHATICS</b>		Hemorrhoids	
Hives		<b>ENDOCRINE</b>		Lymph node swelling		Hepatitis	
Lesions		Cold intolerance		Node tenderness		Hernia	
Melanoma		Diabetes		<b>CANCER</b>		Indigestion	
Psoriasis		Easy bleeding		List type of cancer below		Jaundice/Yellow	
Rash		Excessive appetite				Nausea	
Tumor/growth/cyst		Excessive thirst				Pancreatitis	
<b>OTHER</b>		Excessive urination				Rectal bleeding	
Venereal disease		Gout				Ulcer – gastric	
		Heat intolerance				Ulcer – peptic	
		Thyroid disease				Vomiting	
		Hair loss				Vomiting blood	

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_