PATIENT INSTRUCTIONS Please make sure you complete all 3 pages • Do NOT detach the pages from the stub

INITIAL PATIENT HISTORY & PHYSICAL

This form is to help your doctor give you better health care.
It is completely confidential and will be part of your medical record.
PLEASE MAKE SURE YOU COMPLETE ALL *THREE* PAGES.

M.D.____________________

Today's Date__________ Acc't No. __________

Race__________ Ethnicity__________ Preferred Language__________

Patient Name__________ D.O.B __________

Address __________

__________ Nickname__________

Home Phone__________ Work Phone __________

Lifetime Occupation__________ Retired ☐ Yes ☐ No

Employer __________

Primary Care Physician __________

WHICH PHYSICIAN REFERRED YOU TO US?

____

PLEASE LIST ANY OTHER PHYSICIANS TO WHOM YOU WOULD LIKE COPIES OF INFORMATION SENT:

Name	Address /City/State	Problem Cared For

YOUR PHARMACY:

Name __________

Address __________

Phone__________

List of Allergies: __________

____

LATEX ALLERGY ☐ Yes ☐ No

MARITAL STATUS:
☐ Single ☐ Married ☐ Widowed
☐ Separated ☐ Divorced

LIVING ARRANGEMENT:
☐ Alone ☐ With Spouse / Significant Other
☐ Supervised Living ☐ Other:__________

SERVICES IN YOUR HOME:
☐ None ☐ Aide ☐ Nurse ☐ Meals on Wheels
☐ Home Care Agency Name __________
☐ Other__________

PLEASE CHECK BOXES FOR ITEMS THAT YOU HAVE:
☐ Organ Donor Card ☐ Health Care Proxy ☐ Living Will
☐ Power of Attorney

Would you like more information on any of these? ☐ Yes ☐ No

Information Given: __________ OFFICE USE ONLY

LIST A PERSON WE MAY CONTACT IF WE ARE UNABLE TO REACH YOU.

Name __________

Address __________

____

Home Phone__________ Work Phone__________

Relationship __________

PERSON COMPLETING THIS FORM IF OTHER THAN PATIENT:

REASON FOR SEEING DOCTOR:

LIST ALL MEDICATIONS *YOU* **NOW** TAKE
(Including Non-Prescription Medications And Herbal Remedies)

Medication	Dose	Times Daily

Are You on Oxygen? ☐ Yes ☐ No

FAMILY HISTORY:	Present Age	*or* Age at Death	Present Health *or* Cause of Death
Father			
Mother			
☐ Brother ☐ Sister			
☐ Brother ☐ Sister			
☐ Brother ☐ Sister			
☐ Brother ☐ Sister			
☐ Brother ☐ Sister			
Spouse			
☐ Son ☐ Daughter			
☐ Son ☐ Daughter			
☐ Son ☐ Daughter			
☐ Son ☐ Daughter			
☐ Son ☐ Daughter			

DO ANY OTHER MEMBERS OF YOUR FAMILY HAVE A HISTORY OF CANCER OR BLOOD DISORDER? IF YES, PLEASE EXPLAIN.

NYOH-54042 REV02/14

DO YOU NOW OR HAVE YOU EVER	LIST YEAR YOU LAST HAD	FOR WOMEN ONLY
Smoked Cigarettes? ☐ Yes ☐ No ____Pkgs/Day____#Yrs. When Quit_____ Consumed Alcohol? ☐ Yes ☐ No ____ Drinks / Wk When Quit _____ Consumed Coffee / Tea? ☐ Yes ☐ No _____ Cups / Day Used Street / Illegal Drugs? ☐ Yes ☐ No *Type*___________________________	_________Flu Vaccine _________Hepatitis Vaccine _________Pneumonia shot _________Tetanus Shot _________T.B. Test (PPD) _________Eye Exam _________Dental Exam _________Cholesterol Test _________Stool Blood Test _________Rectal Exam _________Colonoscopy _________Sigmoid Exam	Age at *First* Menstrual Period ________ Age at Menopause________ If still Menstruating, Date of *Last* Period_____________________ Have you ever taken birth control pills? ☐ Yes ☐ No How Long?_______Yrs. Do you now use birth control? ☐ Yes ☐ No *Type* _____________________ Have you *ever* taken hormone replacements? ☐ Yes ☐ No How Long? ___Yrs. Are you *currently* taking hormone replacements? ☐ Yes ☐ No Type____ Number of Pregnancies____ Number of Live Births____ Age at 1st Childbirth ____ Did you breast feed? ☐ Yes ☐ No *How long* _____________________ Year of Last: _______Pap Test ☐ Normal ☐ Abnormal _______Breast Exam ☐ Normal ☐ Abnormal _______Mammogram ☐ Normal ☐ Abnormal

MEDICAL HISTORY

Answer these history questions by checking the appropriate boxes.

HAVE YOU *EVER* HAD:

	▼ For Office Use Only ▼
☐ A Heart Condition ☐ High Blood Pressure ☐ A Stroke	
☐ A Lung Disorder	
☐ Stomach / Gall Bladder Problems	
☐ Jaundice / Hepatitis / other Liver Disorders	
☐ Ulcerative Colitis / Crohn's Disease	
☐ Kidney / Bladder Problems	
☐ Sexual Problems.	
☐ Venereal Disease / Herpes / A.I.D.S	
☐ Arthritis / Chronic Pain	
☐ Frequent Headaches / a Nervous Disorder	
☐ Seizure Disorder	
☐ Depression / Anxiety	
☐ A Thyroid Problem	
☐ Diabetes	
☐ Skin Diseases (Eczema / Psoriasis / Hives)	
☐ Breast / Prostate Problems	
☐ Anemia / Blood Problems	
☐ A Blood Transfusion	
☐ Cancer	
☐ Allergies / Drug Sensitivities	
☐ Asthma / Hives	
☐ Birth Defects / Inherited Diseases	
☐ Measles / Mumps / Rubella / Chicken Pox	
☐ Other Medical Problems:___________________________________	
☐ **No Known Medical Problems**	

HOSPITALIZATIONS Please list those operations or serious illnesses that you have had which required hospitalization. If you have had more than four, check this box ☐.
Do not include pregnancies here.

PRIOR CANCER TREATMENT

Mo./Yr.	Illness or Operation	Complications Yes	Complications No	Mo./Yr.	Radiation Site / Chemo Type	Where Treated
		☐	☐			
		☐	☐			
		☐	☐			
		☐	☐			

ARE YOU ***CURRENTLY*** EXPERIENCING ANY OF THE FOLLOWING? CHECK ***ALL*** THAT APPLY.

CONSTITUTIONAL
- ☐ No problems or concerns
- ☐ Recent weight loss
- ☐ Recent weight gain
- ☐ Fevers / Chills
- ☐ Night sweats
- ☐ Excessive itching
- ☐ Food supplements
- ☐ On a diet now *Type*_____________

_________ Number of meals daily

EYES
- ☐ No problems or concerns
- ☐ Glaucoma
- ☐ Cataracts
- ☐ Vision loss
- ☐ Other:___________________

EAR, NOSE, MOUTH, THROAT
- ☐ No problems or concerns
- ☐ Hearing loss
- ☐ Dental problem
- ☐ Hoarseness
- ☐ Nose bleeds
- ☐ Other:___________________

CARDIOLOGY
- ☐ No problems or concerns
- ☐ High blood pressure
- ☐ Heart murmur
- ☐ Rapid / Irregular heart beat
- ☐ Chest pain / Tightness
- ☐ Pacemaker / Defibrillator
- ☐ Ankle swelling
- ☐ Leg cramps at night
- ☐ Other:___________________

RESPIRATORY
- ☐ No problems or concerns
- ☐ Asthma / Bronchitis / Emphysema
- ☐ Shortness of breath
- ☐ Cough that produces blood
- ☐ Other:___________________

GASTROINTESTINAL
- ☐ No problems or concerns
- ☐ Loss of appetite
- ☐ Heartburn or indigestion
- ☐ Stomach pain or discomfort
- ☐ Frequent nausea / Vomiting
- ☐ Recurrent diarrhea / Constipation
- ☐ Bloody stools
- ☐ Black, tarry stools
- ☐ Difficulty swallowing
- ☐ Other:___________________

(Please do not forget to complete right side column)

▼ Office Use Only ▼

M.D. Signature ______________________ Date ________

GENITOURINARY
- ☐ No problems or concerns
- ☐ Difficulty urinating
- ☐ Frequent / Painful urination
- ☐ Recurrent bladder infection
- ☐ Vaginal itching / Discharge
- ☐ Sexual problems
- ☐ Blood in urine
- ☐ Other:___________________

MUSCULOSKELETAL
- ☐ No problems or concerns
- ☐ Difficulty walking
- ☐ Joint aches or stiffness
- ☐ Painful legs / Feet
- ☐ Back ache / Pain
- ☐ Other:___________________

NEUROLOGIC
- ☐ No problems or concerns
- ☐ Difficulty concentrating
- ☐ Headache
- ☐ Dizziness / Fainting / Blackouts
- ☐ Numbness hands / Feet
- ☐ Seizures / Convulsions
- ☐ Memory changes
- ☐ Other:___________________

PSYCHOSOCIAL
- ☐ No problems or concerns
- ☐ Nightmares
- ☐ Anxious / Nervous
- ☐ Trouble sleeping
- ☐ Lonely / Depressed
- ☐ Work / Family problems
- ☐ Tire easily
- ☐ Other:___________________

ENDOCRINE
- ☐ No problems or concerns
- ☐ Thyroid problems
- ☐ Blood sugar problems
- ☐ Excessive sweating
- ☐ Other:___________________

SKIN / BREAST
- ☐ No problems or concerns
- ☐ Sores / Rashes
- ☐ Moles
- ☐ Nipple discharge
- ☐ Change in breast size
- ☐ Lump / Pain
- ☐ Other:___________________

HEMATOLOGIC / LYMPHATIC
- ☐ No problems or concerns
- ☐ Easy bleeding / Bruising
- ☐ Anemia or blood problem
- ☐ Frequent infections
- ☐ Swelling of glands
- ☐ Swelling of hands / Feet
- ☐ Other:___________________

ALLERGIC / IMMUNOLOGIC
- ☐ No problems or concerns
- ☐ Facial swelling
- ☐ Tightening of throat
- ☐ Hives
- ☐ Other:___________________