

Examination – New Patient

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Date: \_\_\_\_\_

For Office Use Only

<b>CC:</b>	
<b>HPI:</b>	
Location, Duration, Severity (mild, very, worsening), Signs&Symptoms (itchy, pain), Mod.Factors (prior tx), Quality (bleeding, inflamed), Timing, Context	

Allergies to Medications: \_\_\_\_\_

Current Medications: \_\_\_\_\_

**Current or Past Problems with: (Review of Systems)**

Yes	No		Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	General Health	<input type="checkbox"/>	<input type="checkbox"/>	Kidneys
<input type="checkbox"/>	<input type="checkbox"/>	Arthritis/Muscles/Joints	<input type="checkbox"/>	<input type="checkbox"/>	Lung
<input type="checkbox"/>	<input type="checkbox"/>	Blistering Sunburn	<input type="checkbox"/>	<input type="checkbox"/>	Pacemaker
<input type="checkbox"/>	<input type="checkbox"/>	Blood/Bleeding Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Psychological Disorder
<input type="checkbox"/>	<input type="checkbox"/>	Ears/Nose/Throat/Mouth	<input type="checkbox"/>	<input type="checkbox"/>	Radiation Therapy
<input type="checkbox"/>	<input type="checkbox"/>	Eyes	<input type="checkbox"/>	<input type="checkbox"/>	Skin
<input type="checkbox"/>	<input type="checkbox"/>	Headaches/Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Stomach/Bowel
<input type="checkbox"/>	<input type="checkbox"/>	Heart	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid/Diabetes

If Yes to any, explain: \_\_\_\_\_

Females: Are you pregnant? Yes \_\_\_ No \_\_\_      Planning to become pregnant? Yes \_\_\_ No \_\_\_

**Family History:**

	Mother	Father	Siblings	Children
Allergies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
EczeMa	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hayfever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Malignant Melanoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Psoriasis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Skin Cancer-non melanoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

All Negative (No boxes checked)

**Social History:**

Do you live alone? Yes \_\_\_ No \_\_\_      Do you smoke? Yes \_\_\_ No \_\_\_  
 Do you drink alcohol? Yes \_\_\_ No \_\_\_      Do you use recreational drugs? Yes \_\_\_ No \_\_\_

Occupation: \_\_\_\_\_ Hobbies/Leisure activities \_\_\_\_\_

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