NEW PATIENT HEALTH HISTORY
Form and Function Osteopathic Medicine
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Date:____________

Name: ____DOB:____________ Age: ______

Primary Care Physician: ___________________________________Clinic Name and Location:______________________

Medical problem that brought you here today?

____

____

Other associated type of symptoms you are having?

____

____

____

____

MEDICAL History and other medical Problems:

__________________________ __________________________ __________________________

__________________________ __________________________ __________________________

__________________________ __________________________ __________________________

Surgical History:

__________________________ __________________________ __________________________

__________________________ __________________________ __________________________

ALLERGIES: ____

Medications- name only:

__________________________ __________________________ __________________________

__________________________ __________________________ __________________________

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__________________________ __________________________ __________________________

Smoking? ______ If so, how much per day? _________

How much Exercise per week and what kind? ____

Other Hobbies and activities: ____

MEDICAL HISTORY in your family :

Mother____

Father ____

Siblings____

Other____

REVIEW OF SYMPTOMS: Check off any of the following symptoms you have/had *RECENTLY* experienced within the last few WEEKs:

GENERAL: ENT:

___ weight gain/loss ___ headaches ___ eye pain ___ runny nose
___ tired/weak ___ hearing loss ___ stuffy nose ___ bleeding gums
___ dizzy/fainting ___ noise in ears ___ nosebleeds
___ fever/chills ___ blurry vision ___ earaches ___ sore throats

RESPIRATORY:

___ cough ___ cough with phlegm ___ cough with blood ___ wheezing ___ short of breath

HEART:

___ high blood pressure ___ heart races or skips beats ___ chest pain ___ short of breath after climbing steps
___ short of breath while laying in bed ___ legs swell ___ legs hurt or cramp when walking ___ varicose veins

GI:

___ trouble swallowing ___ heartburn ___ poor appetite ___ nausea ___ vomiting ___abdominal pain
___ diarrhea ___ constipation ___ excess belching or passing gas ___ change in stool

URINARY:

___ burning with urination ___ frequent urination ____ change in urine stream
___ frequent urinary infection ___ lose urine if you cough or sneeze ___ kidney stones

MUSCULOSKELETAL:

___ pain in muscles or joints ___ morning stiffness ___ backache ___ sciatica ___ low back pain ___ arthritis
___ gout ___ scoliosis ___muscle spasms

NEUROLOGICAL:

___ blackouts ___ seizures ___ numbness or loss of sensation ___ tingling or "pins and needles"
___ tremors or other involuntary movements ____ weakness in arms or legs ___ trouble walking

ENDOCRINE:

___ heat or cold intolerance ___ excessive sweating ___ excessive thirst or hunger ___excessive urination

PSYCHOLOGICAL:

___ anxiety ___ tension ___depression ___ difficulty with memory ___confusion

DERMATOLOGICAL:

___ skin changes / rash ___ Bleeding ____ Bruising_____non-healing wounds

Other Pertinent Information you wish the Doctor to know:

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____
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