)RTHERN LIGHTS FAMILY IEDICINE

NEW PATIENT HISTORY FORM

Name: _____ Date of Birth: _____ Sex: _____

Address: _____ Telephone: Home: _____ Work: _____

_____ Employer/Occupation: _____

_____

Current/Main medical problem: _____

Wear Glasses? **Y** **N** Blind? **Y** **N** Wear Hearing Aids? **Y** **N** Deaf? **Y** **N**

What specifically do you want to be seen for or have covered at this visit?

_____

_____

PREVIOUS ILLNESSES

_____ Tuberculosis	_____ Lung disease	_____ Heart Problems
_____ Rheumatic Fever	_____ High Blood pressure	_____ Ulcer
_____ Anemia/blood disease	_____ Sickle Cell Anemia	_____ Cancer
_____ Diabetes	_____ Thyroid Disease	_____ Kidney Disease
_____ Serious Injuries	_____ Neurological disease	_____ Liver Disease
_____ Gallbladder Disease	_____ Mental Illness	_____ Other: _____

Please list hospitalizations, surgeries, accidents, operations or major illnesses:

Year	**Illness or Operation**	**Year**	**Illness or Operation**

MEDICATIONS:

Name	Dose	Frequency	Name	Dose	Frequency

Over the counter medications: _____

What supplements, vitamins or herbal preparations do you use? _____

ALLERGIES and ADVERSE REACTIONS

Medications/food/other	Year	Reaction/Symptoms

HEENT:
_____Headaches/dizziness
_____Eyes/Vision
_____Ears/Hearing
_____Hay Fever/Allergies
_____Nosebleed/Sinuses
_____Mouth/Teeth
_____Goiter or Growth

CHEST/RESPIRATORY
_____Wheezing/coughing
_____Shortness of Breath
_____Pain/swelling arms/legs
_____Chest pain/pressure
_____Nipple Discharge
_____Breast Lumps
_____Heart fluttering

SKIN
_____Rash/itching/hives
_____Bruise easily
_____Lumps or growths

GASTROINTESTINAL:
_____Abdominal pain/indigestion
_____Severe Nausea or Vomiting
_____Change in stool habits, bleeding
_____Change in appetite
_____Hernia
_____Hemorrhoids

GENITOURINARY:
_____Painful/burning/difficult urination
_____Blood in urine
_____Vaginal or penile discharge

MUSKULOSKELETAL:
_____Back/joint/muscle pain
_____Tremor/weakness
_____Joint Swelling
_____Broken bones
_____Chiropractic treatment
_____Falling

NEUROLOGY:
_____Seizure disorder
_____Stroke
_____Numbness/tingling

HEMATOLOGY/ENDOCRINOLOGY
_____Chills/Fever/Sweats
_____Lack of Energy
_____Frequent Urination
_____Weight Change

_____ _____Birth Control Method

MEN ONLY:
_____Sexual Problems _____Prostate Problems _____Testicular pain/swelling
Do you perform Testicular Self-exams: _____ If yes, how often? _____

WOMEN ONLY:
Date of Last Mammogram: _____ Do you perform Breast self-exams? _____If yes, how often?
_____
Date of Last Pap test:_____ Abnormal PAP results:_____ Sexual Problems:_____
Date of Last Menstrual Period:_____ Age of Menstrual Onset:_____Hot Flashes:_____
Flow: heavy moderate light Days of flow:_____ Length of Cycle:_____
Pain/cramps w/menstrual flow:_____ Irregular Periods:_____ Bleeding between periods_____
Number of Live Births:_____ Number of Inducted Abortions:_____ Number of Miscarriage:_____

Since your last visit, have you been hit, hurt, threatened or frightened by a friend or relative?
_____
Since your last visit, has anyone forced you to have sexual activities? _____

_____ _____
Patient Signature ***Date*** ***Provider Signature*** ***Date***

HEENT:
_____Headaches/dizziness
_____Eyes/Vision
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WOMEN ONLY:
Date of Last Mammogram: _____ Do you perform Breast self-exams? _____If yes, how often?
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Date of Last Pap test:_____ Abnormal PAP results:_____ Sexual Problems:_____
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Since your last visit, has anyone forced you to have sexual activities? _____

_____ _____

Patient Signature ***Date*** ***Provider Signature*** ***Date***