STEVEN E. FLORES, MD **[COMPLETED BY PATIENT]**
NEW PATIENT HISTORY FORM

Patient Name:_____ Date of visit:_____

Date of Birth:_____ Age:_____ Height:_____ Weight:_____

Referring Doctor:_____

If in school, where? _____

Date of Injury:_____

Injury Occurred: ❑ Playing a sport ❑ At work ❑ Unknown ❑ Other_____

Chief Complaint: ❑Right ❑ Left (please explain)_____

_____

PAST MEDICAL HISTORY *(Please check if you have every had any of the following?)*

- ❑ High Blood Pressure
- ❑ Heart Attack
- ❑ Heart Murmur
- ❑ Heart Disease
- ❑ Mitral Valve Prolapse
- ❑ Emphysema or COPD
- ❑ Asthma
- ❑ Bowel Disorder
- ❑ Stomach Ulcer
- ❑ Diabetes: ❑ Insulin ❑ Oral Meds ❑ Diet
- ❑ Thyroid: ❑ Hypo ❑ Hyper
- ❑ Blood Clots
- ❑ Any bleeding problems
- ❑ Varicose veins
- ❑ Swelling in legs or feet
- ❑ Any kidney problems
- ❑ Seizure or stroke
- ❑ Depression
- ❑ Any other mental condition
- ❑ Muscular skeletal disorder
- ❑ Hepatitis or other blood disorder

❑ **NORMAL, I've had none of the above.**

❑ Fracture(s) (what and when):_____

PAST SURGICAL HISTORY *(if yes, list procedure, body part and when)*

_____

_____

MEDICATION: Are you taking any medication, herbs, or vitamins? (Please list)_____

_____

ALLERGIES to any medications or eggs? YES NO _____

If allergic, what happens:_____

SOCIAL HISTORY: Do you smoke? _____ packs per _____
Alcohol use? ❑Rarely ❑Socially ❑Moderate
Other drug use? _____

FEMALES ONLY: Are you pregnant? ❑Yes ❑No
Taking birth control pills? ❑Yes ❑No How long? _____
On any hormonal therapy? ❑Yes ❑No

FAMILY HISTORY: Any Family History of heart problems, bleeding problems or blood clots
(Immediate family members only)
❑Yes ❑No If yes, which member and which condition?

_____

_____

REVIEW OF SYSTEMS: (PLEASE CIRCLE SPECIFIC COMPLAINT)

❑ **Normal, I have none of the below currently.**

General
- ❑ Do you have any fever, chills or recent illnesses?
- ❑ Have you recently had any weight loss or gain?

Head and Neck
- ❑ Changes in vision, sensitivity to light, blurred or double vision?
- ❑ Change in hearing, bloody nose, sore throat or cough?

Cardiovascular
- ❑ Chest pain, heart palpitations?

Respiratory
- ❑ Shortness of breath, difficulty breathing, wheezing, coughing of blood?

GI
- ❑ Loss of appetite, nausea, vomitting, abdominal pain, diarrhea, constipation?

Renal
- ❑ Difficulty urinating, pain with urination, blood in your urine?

Misc.
- ❑ Current skin problems or wounds?
- ❑ Any swelling or cramping in your legs or feet?

OCCUPATION: _____ ❑Full Duty ❑Light Duty ❑Not Working

Name of your family or medical physician: _____

Address: _____

When did you last see him/her? _____

_____ I have reviewed this PATIENT HISTORY FORM with patient

_____
Physician Signature