

NEW PATIENT FORM

ADULT MALE

DATE \_\_\_\_\_

NAME \_\_\_\_\_

DATE OF BIRTH \_\_\_\_\_

**Current Medications and Dosage (include supplements, vitamins and over-the-counter medications you take everyday) PLEASE BRING YOUR MEDICATION LIST OR BOTTLES WITH YOU:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Allergies to Medications and type of reaction:

\_\_\_\_\_

**Have you ever been diagnosed with: Please give year of diagnosis**

**Heart Problems:** High Blood Pressure \_\_\_\_ High Cholesterol \_\_\_\_ Heart Irregularity \_\_\_\_  
Heart Attack \_\_\_\_ Congestive Heart Failure \_\_\_\_ Coronary Artery Disease \_\_\_\_  
Other \_\_\_\_\_

**Lung Problems:** Asthma \_\_\_\_ Emphysema (COPD) \_\_\_\_ Pneumonia \_\_\_\_ Sleep Apnea \_\_\_\_  
Chronic Cough \_\_\_\_

**Gastrointestinal Problems:** Liver Problems \_\_\_\_ Crohn's Disease \_\_\_\_ Colon Polyps \_\_\_\_  
Stomach ulcers \_\_\_\_ Colitis \_\_\_\_ Reflux/Heartburn \_\_\_\_

**Kidney Problems:** Kidney Stones \_\_\_\_ Kidney Failure \_\_\_\_

**Genitourinary Problems:** Prostate Problems \_\_\_\_ Impotence \_\_\_\_ Overactive Bladder \_\_\_\_

**Musculoskeletal Problems:** Gout \_\_\_\_ Fibromyalgia \_\_\_\_ Chronic Pain \_\_\_\_ Arthritis \_\_\_\_  
Lupus \_\_\_\_ Osteoporosis \_\_\_\_

Any broken bones (which bone and the year of injury) \_\_\_\_\_

**Endocrine Problems:** Diabetes \_\_\_\_ Thyroid Problems \_\_\_\_

**Neurological Problems:** Multiple Sclerosis \_\_\_\_ Parkinson's \_\_\_\_ Migraine Headaches \_\_\_\_  
Seizure Disorder \_\_\_\_ Strokes \_\_\_\_

**Blood Disorders:** Anemia \_\_\_\_ Leukemia \_\_\_\_ Blood disorders \_\_\_\_ Blood Clots (Legs or Lungs) \_\_\_\_

**Allergies:** Seasonal/Hay fever \_\_\_\_ Eczema \_\_\_\_

Psoriasis \_\_\_\_ Frequent Sinus Infections \_\_\_\_

**Cancer:** Bone \_\_\_\_ Brain \_\_\_\_ Colon \_\_\_\_  
Lung \_\_\_\_ Skin \_\_\_\_ Other Cancers \_\_\_\_  
Prostate \_\_\_\_ Testicular \_\_\_\_

**Have you ever been diagnosed with:**

Depression \_\_\_\_ Mood Disorder \_\_\_\_ Bipolar Disorder \_\_\_\_

Eating Disorder \_\_\_\_ Anxiety \_\_\_\_

**Other:** Cataracts \_\_\_\_ Glaucoma \_\_\_\_

AIDS \_\_\_\_ HIV \_\_\_\_

**The Date of Your Last Physical Exam:** \_\_\_\_\_

**List any Specialists you are currently seeing:**

\_\_\_\_\_  
\_\_\_\_\_

**Have you had any surgeries? List Date of Surgery and Location**

Appendix \_\_\_\_ Joint Scope \_\_\_\_ Biopsy \_\_\_\_

Gallbladder \_\_\_\_ Hernia Repair \_\_\_\_ Prostate \_\_\_\_

Joint Replacement \_\_\_\_ Vasectomy \_\_\_\_ Sinus surgery \_\_\_\_

Cataract \_\_\_\_ Heart Valve Replacement \_\_\_\_

Pacemaker Implant \_\_\_\_ Tonsils/Adenoids \_\_\_\_

Open Heart \_\_\_\_

Other Surgeries: \_\_\_\_\_

\_\_\_\_\_

***FAMILY HISTORY: (Includes parents, immediate grandparents, immediate aunts/uncles, and siblings)  
Please state who and their age. Has anyone been diagnosed with:***

High Blood Pressure \_\_\_\_\_ High Cholesterol \_\_\_\_\_  
Heart Attack \_\_\_\_\_ Heart Failure \_\_\_\_\_ Diabetes ("sugar") \_\_\_\_\_  
Low or High Thyroid \_\_\_\_\_ Asthma \_\_\_\_\_ COPD/Emphysema \_\_\_\_\_  
Crohn's Disease \_\_\_\_\_ Colon Polyps \_\_\_\_\_ Reflux Disease \_\_\_\_\_  
Irritable Bowel Syndrome \_\_\_\_\_ Hepatitis/Liver problems \_\_\_\_\_  
Kidney failure \_\_\_\_\_ Kidney Stones \_\_\_\_\_ Fibromyalgia \_\_\_\_\_  
Osteoarthritis \_\_\_\_\_ Osteoporosis \_\_\_\_\_ Rheumatoid Arthritis \_\_\_\_\_  
Seizures \_\_\_\_\_ Migraines \_\_\_\_\_ Multiple Sclerosis \_\_\_\_\_ Stroke \_\_\_\_\_  
Lupus \_\_\_\_\_ Anemia \_\_\_\_\_ Alcoholism \_\_\_\_\_ Depression \_\_\_\_\_  
Anxiety \_\_\_\_\_ Bipolar Disorder \_\_\_\_\_ Cancer \_\_\_\_\_  
Other: \_\_\_\_\_

**SOCIAL HISTORY:**

Occupation: \_\_\_\_\_  
\_\_\_\_\_ Married/Single/Widowed/Divorced  
Number of children: \_\_\_\_\_ Ages: \_\_\_\_\_  
Hobbies: \_\_\_\_\_  
Exercise: Type of Exercise \_\_\_\_\_ Frequency \_\_\_\_\_  
Tobacco Use:  
Cigarettes: \_\_\_ packs per day for \_\_\_ yrs. Cigars: \_\_\_ cigars per week for \_\_\_ yrs.  
Alcohol Intake: Current Alcoholic: \_\_\_ Past Alcoholic: \_\_\_  
Current Use: Rare \_\_\_\_\_ Social \_\_\_\_\_ Regular \_\_\_\_\_  
Alcohol: Beer \_\_\_\_\_ Wine \_\_\_\_\_ Liquor # of Drinks: \_\_\_ per day \_\_\_ per week

**Have you ever used illicit or street drugs? Yes / no**

Current Use \_\_\_\_\_ Prior Use \_\_\_\_\_

**Have you ever had:**

Chlamydia \_\_\_\_\_ Gonorrhea \_\_\_\_\_ Herpes \_\_\_\_\_  
Human Papillomavirus (HPV) \_\_\_\_\_ Syphilis \_\_\_\_\_ Other \_\_\_\_\_  
Measles \_\_\_\_\_ Mumps \_\_\_\_\_ Hepatitis A, B, or C \_\_\_\_\_  
Malaria \_\_\_\_\_ Rocky Mountain Spotted Fever \_\_\_\_\_  
Severe Strep or staph infection \_\_\_\_\_ Diphtheria \_\_\_\_\_  
Rabies \_\_\_\_\_ Tetanus \_\_\_\_\_ Asbestosis \_\_\_\_\_  
Other reportable diseases: \_\_\_\_\_

***PLEASE BRING COMPLETED FORM WITH YOU TO YOUR APPOINTMENT***