Center Medicine: New Patient History

Name:____ **Date:**_______________
Date of Birth:_______________**Height:**________**Weight:**________**Sex:**________________
Address:____
City/State/Zip:____
Phone:____________________**Email:**____
Occupation:____
Marital status: Single, Married, Partner, Divorced, Widowed, Other:_________________________
Emergancy contact:________________________**Phone:**___________________________
How did you hear about this office?____

What are the main issues for which you are seeking treatment?
1)____
2)____
3)____

Are you currently in pain / discomfort? (Y) (N)
Where: ____ **1 2 3 4 5 6 7 8 9 10**
Where: ____ **1 2 3 4 5 6 7 8 9 10**
Where: ____ **1 2 3 4 5 6 7 8 9 10**

What other forms of treatment have you tried and were they helpful?
____
____
____

Are you taking any medications (Prescription, OTC, Herbal, Supplements)?
____
____
____
____
____

Any major medical issues, injuries, hospitalizations in your personal history?
____
____
____
____
____

Any major medical issues in your immediate family (Grand parents, Parents, Siblings)?
____
____
____
____

******please check or circle any that apply to you******

GENERAL

Fatigue	Weight gain / loss	Disrupted sleep
Always hot	Always cold	Cold hands / feet
Hair loss	Swollen glands	Bleed or Bruise easily
Spontaneous sweating	Unable to sweat	Night sweats
Other:		

MUSCULOSKELETAL

Neck pain	Hip pain	Leg cramps
Back pain	Knee pain	Muscle atrophy
Hand/Wrist pain	Foot/Ankle pain	Muscle pain(s)
Elbow pain	Hernia pain	Muscle spasms
Arm pain	Deformities of bones	Muscle weakness
Shoulder pain	Brittle bones	Areas of numbness & Tingling
Rib pain	Joint swelling	Other:

SKIN

Dry	Oily	Rashes
Itching	Eczema	Psoriasis
Fungal infections	Acne	Dandruff
Non healing wounds	Other:	

NEUROLOGICAL

Seizures	Convulsions	Tremors/Tics
Stroke / TIA	Paralysis	Areas numbness / Tingling
Confusion / Brain fog	Lack of coordination/Balance	Poor memory/Concentration
Dizziness	Head injury	Learning disabilities
Other:		

******please check or circle any that apply to you******

PSYCHO-EMOTIONAL

Anxiety / Nervousness	Fear / Fright	Poor Stress tolerance
Depression / Sadness	Anger / Frustration	Worry / Over thinking
Boredom	Driven / Stubborn	Mood Swings
ADD / ADHD	OCD	Mania
Contentment	Joy	Other:

HEAD, EYES, EARS & THROAT

Headaches	Light sensitivity	Earaches
Migraines	Red/Itchy eyes	Ringing in ears
Fainting	Poor night vision	Dizziness
Pressure in eyes/ears	Spots in front of eyes	Sores on lips/tongue
Eye pain	Poor hearing	Grinding teeth
Sore throat	Difficulty swallowing	Nose bleeds
Other:		

RESPIRATORY

Asthma	Bronchitis	Sinus congestion
Allergies	Pneumonia	Catch colds frequently/easily
Cough	Difficulty breathing	Easily winded
Coughing blood	Hoarseness / Loss of voice	COPD
Other:		

CARDIOVASCULAR

High blood pressure	Irregular heartbeat	Swelling of feet/hands
Low blood pressure	Rapid heartbeat/Palpitations	Blood clots
Raynaud’s	Dizziness	Varicose veins
Chest pain / Tightness	Fainting	Other
Anemia	Pace maker	Congestive heart failure
Other:		

******please check or circle any that apply to you******

GASTROINTESTINAL

Increased appetite	Bad breath	Mouth sores
Decreased appetite	Belching	Excessive thirst
Nausea	Hiccups	Bleeding gums
Vomiting	Gas	Heartburn/Reflux/Indigestion
Ulcers	Hernia	Parasites
Peculiar tastes/smells	Constipation	Vomiting
Gallstones	Diarrhea	Food allergies
Hepatitis	Loose stools	Desire for hot/cold foods
Hemorrhoids	Bloating	Dark/Light/Bloody stools
Other:		

Urinary

Pain with urination	Frequent urination	Urgent urination
Cloudy urine	Blood in urine	Kidney stones
Weak or interrupted stream	Waking to urinate	Other:

Reporductive (Female)

Age menses began: _____	Irregular/No Period	Age at menopause: ______
Cycle length: ______ days	Days of bleeding: ______	Heavy/Light periods
Menstrual blood color: _____	Menstrual pain	Clots
PMS	Breast problems	Method of birth control:
Are you pregnant: Yes No	Number of pregnancies: ____	Number of live births:______
Difficult birth/caesareans	Pain with intercourse	Increased/Decreased libido
Pelvic inflammatory disease	Polycystic Ovarian Disease)	Endometriosis
Hot flashes	Vaginal dryness	Night sweats
HPV positive: Yes No	Vaginal discharge/sores	Sexually transmitted illness
Fertility Issues		Other:____________________

Reporductive (Male)

Prostrate problems	Painful/Swollen testicles	Discharge
Erectile dysfunction	Increased/Decreased libido	Sexually transmitted illness
Fertility Issues	Other:	

Is there anything thing else that seems relevant or that you would like me to know ?

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