Reedsburg
AREA MEDICAL CENTER

Date: _____

NEW PATIENT HISTORY FORM

First Name: _____ Middle Initial: _____ Last Name: _____ Age: _____

DOB: _____ Gender: Male / Female Social Security Number:_____

Address: _____

City/State: _____ Zip code: _____ Occupation: _____

Phone: (Home) _____ (Work)_____ (Cell) _____

E-mail: _____ Preferred Method of Contact _____

Primary Care Provider (PCP): _____ Provider Location: _____

PCP Phone number: (_____) _____ FAX: (_____) _____

Referring Physician: _____ Physician's location: _____

Phone number: (_____) _____ FAX: (_____) _____

Emergency Contact Name: _____ Phone number: (_____) _____

Insurance: _____ ID: _____ Group ID: _____

Chief Complaint: _____

History of Present Illness:

- **Onset**: When did the problem start? _____
- **Course:** Is the problem improving --- stable --- worsening? (circle one)
- **Duration:** How long have you been suffering from this problem? _____
- Lowest Adult Weight: _____ When? _____
- Highest Adult Weight: _____ When? _____
- Female patients:

  Number of pregnancies: _____, Number of deliveries: _____, Number of abortions/miscarriages: _____

How did you hear about our office? Google Social Media Billboard Family/Friend Other:_____

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Review of Systems (please circle)

SYSTEM	SYMPTOM
General	None Fever/Chills Hair Loss
Skin	None Rash Ulcers Skin Changes
Psychiatric	None Mood Swings Suicidal/homicidal ideation Visual/auditory hallucinations
Neurological	None Headaches Numbness/tingling Upper extremity weakness Stroke Memory problems Speech problems
Eyes	None Pain Discharge Vision Problems
Ear/Nose/Throat	None Dizziness Swollen neck glands Sore throat Dental problems oral ulcers/sores
Cardiovascular	None Chest Pain Shortness of breath Leg Swelling Heart Racing
Respiratory	None Coughing up blood Wake up Gasping Excessive daytime drowsiness Cough Asthma Night sweats Snoring
Gastrointestinal	None Heartburn Constipation/diarrhea Blood per rectum Nausea/Vomiting Abdominal pain
Genitourinary	None Discharge Ulcers/sores Pain with urination Bladder/Kidney infections Blood in urine Increased frequency of urination Kidney Stones Males: Scrotal pain Scrotal swelling Female: Irregular menses Painful menses Too much/too little blood flow Pain with intercourse
Endocrine	None Excessive thirst Increased facial or body hair Decrease in facial or body hair Intolerant: hot/cold temperatures
Musculoskeletal	None Joint Pain Limited joint motion Joint Redness/swelling
Lymphatic	None Swollen glands Leg swelling

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Please Initial:

_____ I certify that I will discuss any problems I circled in the Review of systems above with my Primary Care Provider.

Medical History: _____

_____

_____

_____

Surgical History: _____

_____

_____

_____

Medications:

Please list all medications <u>including</u> herbal supplements, vitamins, over the counter drugs, birth control.
If more space is needed, please add supplemental paper(s)

Medication	Dose	Frequency	Indication/Reason

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Type	**Allergen**	**Reaction**
Medications		
Food		
Environmental		
Betadine/Iodine	YES NO	
Oral/IV contrast	YES NO	
Other (Please Specify)		

Allergies:

Social History:

1. Tobacco use: Y / N If yes, specify type: _____ Amount per day: _____ How many years? _____
2. Do you drink alcohol? Y / N Do you have a history of alcoholism? Y / N Years sober: _____

   If yes to either, please specify:

   Type of alcohol: _____ how much: _____ how often: _____
3. History of drug abuse? Y / N

   If yes, specify type: _____ how much: _____ how often: _____

Family History:

Mother: _____

Father: _____

Brother: _____

Sister: _____

Grandma: _____

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Grandpa: _____

Patient Name (print): _____

Patient Signature: _____ **Date**: _____

Provider Signature: _____