EISENHOWER MEDICAL ASSOCIATES

New Patient Worksheet

For Appointment Scheduled with: ______________________________
Date: ________________ Time: ______________________________

Personal Information (Please PRINT and complete all sections)

Patient Name ______________________ Date of Birth ______________
Address ______________________ Gender M F
City ________________ St ______ E-mail ______________
Zip ______________________ Phone ______________
Cell ______________________

Social /Household – Who lives at home with you?

Name	Relationship	Age	State of Health

Health Considerations

Living Will Y N
Advanced Directive Y N
Organ Donor Y N

*Bring copy with you

Medical Information

Main concern(s) that brought you in today.
1.
2.
3.
Medication Allergies / Reaction: ______________
____
____
____
Other Allergies: ______________________
____

Immunizations	***Date***
Flu	________
Tetanus	________
TB	________
Hepatitis B	________
Pertussis(whooping cough)	________
Hepatitis A	________
Shingles	________
Pneumonia VAX	________

Tests / Procedures			Date	Where was procedure done?
Colonoscopy	Y	N		
Mammogram	Y	N		
PAP	Y	N		
Bone Density	Y	N		
Stress Test	Y	N		

Medical Conditions

(Conditions you currently have or have had in the past) **Please indicate the date of diagnosis**.

	Date		Date
AIDS		Herpes	
Alcoholism		High cholesterol	
Anemia		Hypertension	
Anorexia		Kidney disease	
Arthritis		Liver disease	
Asthma		Measles	
Bleeding disorders		Migraine headaches	
Breast lump		Miscarriage	
Bronchitis		Mononucleosis	
Bulimia		Multiple sclerosis	
Cancer		Mumps	
Cataracts		Pneumonia	
Chemical dependency		Polio	
Chicken pox		Prostate problem	
Diabetes		Psychiatric issues	
Dementia		Rheumatic fever	
Emphysema		Scarlet fever	
Epilepsy		Stroke	
Glaucoma		Suicide attempt	
Goiter		Thyroid problems	
Gonorrhea		Tonsillitis	
Gout		Tuberculosis	
Heart disease		Ulcers	
Hepatitis		Vaginal infections	
Hernia		Venereal disease	

Any additional details regarding the above items:

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* Please bring all Medications and Supplements/Vitamins with you to your first appointment.

Prescription Medications

Name	Strength /Dose	How Often	Reason for taking	How Long	Prescribed by

Over The Counter Medications

Name	Strength /Dose	How Often	Reason for taking	How Long	Prescribed by

Vitamins / Supplements

Name	Strength /Dose	How Often	Reason for taking	How Long	Prescribed by

Previous Surgeries / Hospitalization Date Treating Physician

____

____

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____

Present Specialists that you see:

Name Specialty Phone Number

____

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Health Status

General Health	***NO***	***YES***	***Respiratory***	***NO***	***YES***
Fatigue			Shortness of breath		
Weight loss			Chronic cough		
Weight gain			Blood in sputum		
Fevers			Wheezing		
Chills			Chest wall pain		
ENO	***NO***	***YES***	***Heart***	***NO***	***YES***
Double vision			Chest pain		
Blurred vision			Heart palpitations or pounding		
Light sensitivity			Irregular heart rate		
Reduced vision			Shortness of breath /lying down		
Eye redness			Shortness of breath while sleeping		
Eye itching or discharge			Swollen legs or feet		
Eye pain			Leg pain or cramps at rest or walking		
Wear glasses			***Breast Health***	***NO***	***YES***
Glaucoma			Discharge from nipple		
Cataracts			Breast tenderness		
Ears	***NO***	***YES***	Breast mass		
Ear discharge			***Gastrointestinal***	***NO***	***YES***
Ear pain			Loss of appetite		
Ringing or buzzing in ears			Difficulty swallowing		
Hearing loss			Abdominal pain		
Nose / Throat	***NO***	***YES***	Nausea		
Nasal /sinus congestion			Vomiting		
Nasal discharge			Change in bowel habits		
Postnasal drip			Diarrhea		
Sneezing			Constipation		
Nose bleeds			Blood in stool		
Sore throats			Hemorrhoids		
Bleeding gums					
Hoarse voice					

Health Status Continued

Male health	***NO***	***YES***	***Skin***	***NO***	***YES***
Painful urination			Rash		
Blood in urine			Change in mole/lesion (size, color)		
Urethral discharge			Dry skin		
Slowing of urinary stream			Itching of skin		
Dribbling of urine			Nail problem		
Awaken in night to urinate			***Neurologic***	***NO***	***YES***
Testicular mass			Headache		
Testicular pain			Dizziness		
Erectile dysfunction			Lightheadedness		
Female health	***NO***	***YES***	Loss of consciousness		
Increased frequency of urination			Vertigo		
Painful urination			Weakness		
Blood in urine			Numbness		
Awaken in night to urinate			Abnormal skin sensation-tingling		
Urinary leakage / incontinence			Tremor of hands - head		
Vaginal discharge			***Psychiatric***	***NO***	***YES***
Abnormal vaginal bleeding			Difficulty sleeping		
Pelvic pain			Mood swings		
Menstrual problem			Feeling anxious		
Menopausal problem			Feeling depressed		
Vaginal dryness			Confusion		
Painful intercourse			Memory loss		
Last menstrual period Date:			***Endocrine***	***NO***	***YES***
Hematology	***NO***	***YES***	Excessive appetite		
Swollen glands			Excessive thirst		
Lymph node tenderness			Excessive urination		
Anemia			Thyroid problems		
Bruises easily			Intolerant of cold		
Bleeds easily			Intolerant of heat		
Musculoskeletal	***NO***	***YES***	***Immunologic***	***NO***	***YES***
Neck stiffness			Hives		
Neck pain			Susceptibility to infections		
Back stiffness			Impaired wound healing		
Back pain					
Joint swelling					
Join pain					
Limitation of joint movement					
Muscle pain					

Family History

Relation	*Age*	*State of Health*	*Age at Death*	*Cause of Death*	*Check if your blood relatives had any of the following:*		
Father					✓	*Disease*	*Relation to you*
Mother						Cancer	
Brothers						Diabetes	
						Heart Disease, Stroke	
						High Blood Pressure	
						Tuberculosis	
						Mental health problem	
Sisters						Alcohol or drug abuse	
						Osteoporosis	

Pregnancies

Pregnancies	*Number*	*Complications if any*
Full term pregnancies		
Full term births		
Premature births		
Vaginal births		
C-sections		

Health Habits

Check (✓) which substances you use and describe how much you use.		
	Caffeine	
	Tobacco	
	Drugs	
	Alcohol	
	Other	

Occupational Exposure

Occupation:	
Check (✓) if your work exposes you to the following.	
	Heavy lifting
	Chemicals/dust
	Other

Exercise

Type of exercise	*How often*

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature ____ Date __________________________

Data Entered _________ by __________