New Patient Form

Name: ___________________ Gender: ________ Date of Birth: __________

Reason for Visit: ____

Allergies: ____

List ALL MEDICATIONS you take, including over-the-counter medications and vitamins. *Include specific doses and when taken.*

___________________________________ ___________________________________ ___________________________________

___________________________________ ___________________________________ ___________________________________

___________________________________ ___________________________________ ___________________________________

Past Medical History: *(Please circle all that apply)*

Heart Attack	Hypertension	Heart Disease	High Cholesterol	Peripheral Vascular Disease
Diabetes Mellitus *(If yes please fill out page 3)*	Neuropathy	Kidney Disease	Osteoporosis *(If yes please fill out page 4)*	Thyroid Disease
Anemia	Depression	Cancer: _________	Crohn's Disease	Arrhythmia
Arthritis	Sleep Apnea			Other ______________

Past Surgical History: Please list all prior surgeries and approximate dates performed.

____

____

Family History:

Heart Disease: _________________________________ Thyroid Disease: ______________________________

Diabetes Mellitus: ______________________________ Osteoporosis/Osteopenia: _______________________

High Cholesterol: _______________________________ Other: _______________________________________

Social History:

Education level:

- ☐ Elementary ☐ High School ☐ College ☐ Graduate

Smoking/Tobacco Use:

- ☐ Current ☐ Past ☐ Never Amount: ______ # of Years: _________

Alcohol:

- ☐ Current ☐ Past ☐ Never Drinks/week: _______

Review of Systems:

Weight Change	Appetite Change	Headaches	Cold Symptoms	Cough	Shortness of Breath	Chest Pain	Voice Changes
Hot Symptoms	Leg Swelling	Palpitations	Abdominal Pain	Dizziness	Frequent Urination	Joint Pain	Pain with Urination
Joint Swelling	Vision Problems	Confusion	Nausea/Vomiting	Skin Lesions	Feeling Anxious	Bone Pain	Irregular Periods

Patient Signature: ____ Date: ________________

New Patient Form – Diabetes Mellitus

What type of diabetes do you have? (Circle one)

Type 1 Diabetes   Type 2 Diabetes   I'm Not Sure

When were you diagnosed with diabetes? ______________________________

What was your last hemoglobin A1C? ____________________ When was it? __________

Do you have any known complications due to diabetes? If yes, circle all that apply

Yes   No

Diabetic Retinopathy   Nephropathy   Peripheral Neuropathy

Peripheral Vascular Disease   Nephropathy   Peripheral Neuropathy

When and where was your last eye exam? ____________________________________

How often do you check your glucose? ____________________________________

What do you eat for breakfast? ____________________________________

What do you eat for lunch? ____________________________________

What do you eat for dinner? ____________________________________

Who previously managed your diabetes? ____________________________________

Patient Signature: ____ Date: ____________________

New Patient Form – Osteoporosis

When were you diagnosed with osteoporosis? ___________________________________

When and where was your bone density (DEXA) scan? ____

Have you been on any previous osteoporosis medications, if yes which one? ____

Have you had any fractures in the past year? ____

Do you use a cane, walker, assisted device when walking? ____

Do you have any thyroid or parathyroid disease history? ____

Does osteoporosis run in your family? ____

Patient Signature: ____ Date: __________________