

**Laura Jozewicz, MD, PA.**  
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### New Patient History Form

Name : \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_ Race: W B H A

Right Handed \_\_\_\_\_ Left Handed \_\_\_\_\_

Present complaints or symptoms (list separately)

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Review of symptoms (circle all that apply):

<u>Systematic</u>	<u>HEENT</u>	<u>GI</u>	<u>GU</u>	<u>Pulmonary</u>
Fever	headache	heartburn	sexual dysfunction	cough
Weight loss/gain_ lbs	sinus	stomach pain	urinary tract infection	shortness of breath
Fatigue	ringing of ears	bowel changes	urinary complaints	wheezing
Appetite increase/dec.	snoring	cancer	kidney stones	
Depression	excess sleepiness	liver problems	prostate problems	
		Gallbladder	vaginal discharge	
			Menstrual changes	
<u>Muscle Joint</u>	<u>CNS</u>	<u>Endocrine</u>	<u>Blood</u>	<u>CVS</u>
Joint pain	dizziness	thyroid	anemia	chest pain
		Problems		
Muscle aches	leg/hand numbness		lymph node swelling	heart palpitations
Weakness	leg/hand weakness		bleeding tendency	calf pain
Backache	sleep problems			
Mouth sores	headache			
	Problems with balance			
	Difficulty walking			
	“spells”			

Past medical history

Diabetes _____	Hypertension _____	High Cholesterol _____
Thyroid problems _____	Heart Attack/failure _____	Stroke _____
Emphysema/Asthma _____	Arthritis _____	Peptic Ulcer/Hiatial Henia _____

Prior Surgeries (give year)

Hysterectomy _____	Gallbladder Surgery _____
Tonsillectomy/Adenectomy _____	Appendectomy _____
By-Pass(Heart/Femoral) _____	Laminectomy (Lumber/cervical) _____

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Other \_\_\_\_\_ mastectomy \_\_\_\_\_

**Medications**

Please list all medications below (prescriptions and over-the counter)

	Name	Dose & Interval	Who Prescribed
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____
6.	_____	_____	_____
7.	_____	_____	_____

**Allergies**

Medications  
Shrimp/Seafood  
IVP Dye

**Social History**

Marital Status:      Married      Single      Divorced      Separated  
Children \_\_\_\_\_ Age \_\_\_\_\_

	How many years?	How much a day?	If quit, when?
Smoking	_____	_____	_____
Alcohol	_____	_____	_____
Other Drugs (Cocaine, marijuana, intravenous)	_____	_____	_____

**Occupation**

Present \_\_\_\_\_  
Retired \_\_\_\_\_  
Disabled \_\_\_\_\_

**Family History**

High Cholesterol _____	Headache/Migraine _____
Cancer _____	Multiple Sclerosis _____
Heart condition _____	Stroke _____
Lupus _____	Parkinson's _____
Diabetes _____	Seizures _____
Thyroid _____	Rheumatoid Arthritis _____
Alzheimer Disease _____	

**Primary Physician**

Name \_\_\_\_\_ Telephone \_\_\_\_\_ Last seen \_\_\_\_\_  
Signature \_\_\_\_\_ Date \_\_\_\_\_