New Patient Medical History **Date:** ____________

Patient Name: ____________________ **Do you have an Advance Directive? (Only Medicare PT's)** YES NO

Reason for visit: ____

Primary Care Physician: ____________________ Phone: ________________________

Patient's occupation: _______________________ Employer: ________________________

Are you breast feeding and/or pregnant? YES NO

Please list ALL Medications (Prescription, Over-the-Counter Medications, Vitamins):

____ ____

____ ____

____ ____

____ ____

Do you have any allergies to the following:

Sulfa Drugs .....Yes/No **Codeine......Yes/No** **Penicillin..... Yes/No** **Aspirin...Yes/No**

Hydrocodone.....Yes/No **NSAIDS.....Yes/No** **Local Anesthetic....Yes/No** **Latex....Yes/No**

Adhesive Tape..... Yes/No **Other (please list):**____

PAST MEDICAL HISTORY:

Do you have or have you had any of the following diseases or problems?

1. **Anemia... Yes No**
2. **Arthritis.. Yes No**
3. **Diabetes.. Yes No**
4. **HIV/AIDS.. Yes No**
5. **Stomach Ulcer/GERD.. Yes No**
6. **High Blood Pressure... Yes No**
7. **Heart Disease, Heart Attack, A.Fib, Angina, Stroke, arteriorsclerosis or any other heart condition (i.e chest pain, shortness of breath, ankle swelling..Yes No**
8. **Asthma...Yes No**
9. **Allergies or Hay Fever .... Yes No**
10. **Hepatitis or Jaundice of the Liver.. Yes No**

11. **Thyroid Problems .... Yes No**
12. **Respiratory Problems (COPD, Emphysema)... Yes No**
13. **Osteoporosis.. Yes No**
14. **Kidney Problems.. Yes No**
15. **History of Cancer (If Yes, Please Specify).. Yes No**
16. **Any other disease(s) or problem(s) not listed?.............Yes/No (please specify)**_________________________

SURGICAL HISTORY:

Please list ALL surgeries that you have had:

____ ____

____ ____

FAMILY HISTORY:

Family history: Mother: Alive Deceased Health History: ______________________

Father: Alive Deceased Health History: ______________________

How many? Brother(s): ____ **Sister (s)** _____ **Health History:** _____________________

Son(s): _____ **Daughter(s):**____ **Health History:** ______________________________

SOCIAL HISTORY:

Smoking Status: (Please circle one) Current Smoker Former Smoker Non-smoker

Chewing Tobacco: (Please circle) Never Current user Former user

Do you drink alcohol? YES NO **If yes, what type?** Wine Beer Liquor **How often?** Socially Daily Rarely

Do you exercise regularly? YES NO **If yes, what type?** Walking Running Biking Swimming Hiking Yoga Pilates Zumba Other

Use of recreational drugs? YES NO **If yes, what type**? _______________ **How often?** _____________

VITALS:

Shoe size: _______________ **Height**: (***preferably in inches**): _______________ **Weight**: ________________

Review of Systems:

Please indicate by stating Yes or No if you have any of the following :

Endocrine:

Feeling Cold/Cold Intolerance
Diabetes
Excessive Thirst

Respiration:

Trouble Breathing/ COPD
Chest Pressure/Congestion
Cough
Dry Mouth
Shortness of Breath

Cardiology:

Chest Pain
Dizziness
Fainting
Fatigue
High Blood Pressure
History of Heart Attack
Irregular Heartbeat/Heart Murmur
Known Coronary Artery Disease
Ankle/Leg Swelling
Pacemaker
Palpitations

Gastroenterology:

Abdominal Pain
Acid Reflux
Blood in Stool/Rectal Bleeding
Constipation
Diarrhea
Nausea/Vomiting
Weight Gain/Weight Loss
Stomach Ulcer

Musculoskeletal:

Muscle Pain
Splinter/Foreign Object in Foot
Arthritis

Dermatologic:

Lesions
Plantar Warts
Dry/Sensitive Skin
Nail Changes
Foot Ulcers
Thickened Toenails
Ingrown Toenail

Integumentary:

Healing Problems
Melanoma/Skin Cancer
Suspicious Moles
Suspicious Lesions
Easy Bruising

Neurologic:

Balance Difficulty
Burning in Hands/Feet
Confusion
Gait Abnormalities
Headaches/Migraine Headaches
Loss of Sensation
Memory Loss
Peripheral Neuropathy
Seizures
Strokes
Tremors
Tingling/Numbness in Hands/Feet
Visual Changes
Weakness

COVID-19 SCREENING

1. **Have you travelled outside of the country within the past month?.....Yes/No**

2. **Have you travelled to Washington, California, New York, Colorado, Illinois or any other state with high rate of positive Coronavirus?...........Yes/No**

3. **Do you have (or have you had) any respiratory issues or flu-like symptoms within the past month?..............Yes/No**

4. **Is anyone in your household sick?................Yes/No**

5. **Have you had contact with ANYONE with Coronavirus?..................Yes/No**

6. **Have you had any contact with anyone with flu-like symptoms?...............Yes/No**