MILLER HEALTH AND MEDICAL

NEW PATIENT HISTORY

INFORMATION

NAME_____ AGE_____ DATE_____

ALLERGIES_____ REFERRED BY_____

EMPLOYED BY_____ POSITION_____

PART TIME JOB_____ STUDENT- Y/N SCHOOL_____

MAIN SYMPTOMS

What is the main health problem you are having or what is the purpose of this doctor's appointment?

_____

_____

_____

MEDICAL HISTORY

MEDICATIONS (dosages and # each day) _____

_____

_____

_____

SUPPLEMENTS - VITAMINS, MINERALS, HERBS, HOMEOPATHIES

_____

_____

SURGERIES and YEAR_____

_____

DOCTORS – PREVIOUS AND CURRENT_____

_____

PERSONAL HABITS

Please let us know about your individual lifestyle.

Do you smoke? Cigarettes___ Pipe___ Cigar___ Pot___ Do you use? dip___chew___

Previously or Currently- How much a day?_____ For how long?_____

If you stopped, how long ago was it? _____

How often do you drink alcohol?_____ How much?_____ What kind?_____

How many hours do you sleep?____Do you have trouble going___ or staying___ asleep?

Have you been told that you snore loudly?__or briefly stop breathing while sleeping?___

How often do you have bowel movements?_____Soft___ Hard___ Loose___?

How much caffeine do you drink a day? #___oz. Coffee___ Tea___ Pop___ Diet Pop___

How much water do your drink a day? #___oz. Tap___ Bottled___ Filtered___

Do you attend church? _____. If so, where?_____

How often do you exercise?_____ What type?_____

How many minutes do you exercise?_____ How long have you done this routine? _____

What pets do you have?_____

What do you do to relax or have fun, when you aren't doing house chores, working or taking care of your family?_____

What causes you the most stress in life?_____

FAMILY HISTORY

List which relative, if any, had the following illnesses:

Alcoholism_____ Depression_____

Heart attack_____ Stroke_____ Diabetes_____

Thyroid Disease_____ Other_____

Cancer_____

If any of your immediate family has passed away, explain how they died and when.

_____

PERSONAL INFORMATION

How much education did you complete?_____

What is your marital status? Single Divorced Separated Widowed Married

How many times have you been married? _____

How many years for each marriage? 1st_____ 2nd _____ 3rd _____ 4th _____ 5th _____

Name of Spouse or Significant-Other/Live in partner_____

Occupation_____ Employer_____

Children: List the name and ages._____

_____

_____

Grandchildren: List the name and ages._____

_____

_____

MEDICAL PROCEDURES

When did you last have these tests done?

Tests	Never	Where was the test done?
Blood Work_____	_____	_____
EKG _____	_____	_____
Chest X Ray _____	_____	_____
Colonoscopy_____	_____	_____

Please list any other past Procedures and/or Medical Tests

_____

MRI_____

CT _____

EGD_____ ULTRASOUND_____ STRESS TEST_____

MALE QUESTIONS

Have you had your blood tested to check your prostate? (PSA) _____

If you have, when was the most recent test? _____

When have you had a prostate rectal exam? _____

Have you had Benign Prostate Hypertrophy? _____

Have you had Prostate Cancer? _____

If so, when and what type of treatment did you have?_____

Do you do a self-exam of the testicles regularly?_____

What type of contraception do you and your partner use?_____

Birth Control Pills or Patches_____ Condoms____ Depo Provera Shot_____ IUD_____

Diaphragm_____ Tubal Ligation _____ Hysterectomy____ Menopause____

Withdrawal_____ Nothing _____

Do you have trouble starting or stopping your urine? _____

Do you get up more than one time in the night to urinate? _____

Have you noticed a change in your ejaculations? _____

Do you have any problems with erections? _____

Do you have any problems with your sexual interest?_____

How often do you want sex? _____ How often does your partner want sex? _____

Have you experienced decreased muscle strength? _____

Do you find you have diminished stamina? _____

Have you developed a bigger belly than you want? _____

How much weight have you lost in the past year? _____

How much have you gained in the past year_____? Past 5 years?_____

Are you concerned about losing the hair on your head? _____ Never_____