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## New Patient Form

Patient Name: \_\_\_\_\_

Date: \_\_\_\_\_

Age: \_\_\_\_\_  Male  Female

Reason for visit: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Referring Physician: \_\_\_\_\_  MD  Friend  Patient

Primary Care Physician: \_\_\_\_\_

### Medical Problems:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### Previous Surgeries:

Appendectomy \_\_\_\_\_  
 Tonsillectomy \_\_\_\_\_  
 Hernia Repair \_\_\_\_\_  
 Gallbladder \_\_\_\_\_  
 Hysterectomy \_\_\_\_\_

### Allergies to medications:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### Current Medications:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Provider Initials: \_\_\_\_\_

**Social History:**

Occupation: \_\_\_\_\_

Working:  Full time  Part time  Student

If not working, are you:  Retired  On disability  Unemployed

Marital status:  Married  Single  Divorced  Widowed

Number of children: \_\_\_\_\_

Do you use tobacco products?  Yes  No  I Quit, when \_\_\_\_\_

Number of Packs per day: \_\_\_\_\_

Do you drink alcohol?  Yes  No  I Quit, when \_\_\_\_\_

Number of drinks per day: \_\_\_\_\_

Do you use street drugs?  Yes  No  I Quit, when \_\_\_\_\_

Which drugs: \_\_\_\_\_

Are you Pregnant?  Yes  No  N/A

**Family History:** (List which family member)

- High Blood Pressure
- Cancer:  Breast  Lung  Prostate  Thyroid  Skin  other: \_\_\_\_\_
- Heart disease
- Diabetes
- Thyroid Disease
- Anesthesia Complications
- Other: \_\_\_\_\_

**How is your pain Level Today:**

No Pain Severe Pain

0 1 2 3 4 5 6 7 8 9 10

Are you taking anything for your pain? \_\_\_\_\_

Provider Initials: \_\_\_\_\_

**Review of System:** (Check all that apply)

GENERAL HEALTH:  Good  Fair  Bad

**Recent:**

- |   |                                      |  |
|---|--------------------------------------|--|
| <input type="checkbox"/> Weight loss      | <input type="checkbox"/> Weight gain | <input type="checkbox"/> Sweats          |
| <input type="checkbox"/> Chills           | <input type="checkbox"/> Fevers      | <input type="checkbox"/> Chronic fatigue |
| <input type="checkbox"/> Trouble sleeping |                                      |  |

**SKIN:**

- |                                    |                                      |                                |
|------------------------------------|--------------------------------------|--------------------------------|
| <input type="checkbox"/> Rashes    | <input type="checkbox"/> Acne        | <input type="checkbox"/> Scars |
| <input type="checkbox"/> Psoriasis | <input type="checkbox"/> Other _____ |                                |

**EYES:**

- |                                   |   |                                      |
|-----------------------------------|---|--------------------------------------|
| <input type="checkbox"/> Glasses  | <input type="checkbox"/> Contacts       | <input type="checkbox"/> Cataracts   |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Blurred vision | <input type="checkbox"/> Other _____ |

**EARS, NOSES and THROAT:**

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Dentures or partial plates            | <input type="checkbox"/> Braces               | <input type="checkbox"/> Caps              |
| <input type="checkbox"/> Loose teeth                           | <input type="checkbox"/> Taste problems       | <input type="checkbox"/> Smelling problems |
| <input type="checkbox"/> Recent sore throat or sinus infection |   | <input type="checkbox"/> Ringing in ears   |
| <input type="checkbox"/> Dizziness                             | <input type="checkbox"/> Neck lumps or masses |  |

**GLANDULAR PROBLEMS:**

- |                                    |                                 |                                  |
|------------------------------------|---------------------------------|----------------------------------|
| <input type="checkbox"/> Thyroid   | <input type="checkbox"/> Goiter | <input type="checkbox"/> Ovaries |
| <input type="checkbox"/> Testicles |                                 |                                  |

**ENDOCRINE PROBLEMS:**

- |   |                                    |   |
|---|------------------------------------|---|
| <input type="checkbox"/> Excessive thirst | <input type="checkbox"/> Urination | <input type="checkbox"/> Growth of hair |
|---|------------------------------------|---|

**ALLERGY:**

- |                                    |                                      |                                |
|------------------------------------|--------------------------------------|--------------------------------|
| <input type="checkbox"/> Hay fever | <input type="checkbox"/> Asthma      | <input type="checkbox"/> Hives |
| <input type="checkbox"/> Metal     | <input type="checkbox"/> Other _____ |                                |

Provider initials: \_\_\_\_\_

**HEART/VASCULAR:**

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Chest pain               | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Heart attack              |
| <input type="checkbox"/> Congestive heart failure | <input type="checkbox"/> Dyspnea             | <input type="checkbox"/> Rheumatic fever           |
| <input type="checkbox"/> Heart murmur             | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Hardening of the arteries |
| <input type="checkbox"/> Stroke                   | <input type="checkbox"/> Anemia              | <input type="checkbox"/> Dropsy                    |
| <input type="checkbox"/> Ankle swelling           | <input type="checkbox"/> Racing heart beat   | <input type="checkbox"/> Palpitation               |
| <input type="checkbox"/> Irregular beat           |  |  |

**LUNGS:**

Current or recent:

- |                               |                                |   |
|-------------------------------|--------------------------------|---|
| <input type="checkbox"/> Cold | <input type="checkbox"/> Cough | <input type="checkbox"/> Sore throat or infection |
|-------------------------------|--------------------------------|---|

History of:

- |                                     |                                    |  |
|-------------------------------------|------------------------------------|--|
| <input type="checkbox"/> Asthma     | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Tuberculosis      |
| <input type="checkbox"/> Pleurisy   | <input type="checkbox"/> Cough     | <input type="checkbox"/> Coughing up blood |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Sputum    | <input type="checkbox"/> Wheezing          |
| <input type="checkbox"/> Smoking    | <input type="checkbox"/> COPD      | <input type="checkbox"/> Emphysema         |

**GASTRO-INTESTINAL:**

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Hepatitis       | <input type="checkbox"/> Jaundice                      | <input type="checkbox"/> Mouth problems             |
| <input type="checkbox"/> Tonsillitis     | <input type="checkbox"/> Esophagitis                   | <input type="checkbox"/> Hernia                     |
| <input type="checkbox"/> Gallbladder     | <input type="checkbox"/> Change of bowel habits        | <input type="checkbox"/> Typhoid fever              |
| <input type="checkbox"/> Hemorrhoids     | <input type="checkbox"/> Piles                         | <input type="checkbox"/> Nausea                     |
| <input type="checkbox"/> Vomiting        | <input type="checkbox"/> Diarrhea                      | <input type="checkbox"/> Constipation               |
| <input type="checkbox"/> Recent bleeding | <input type="checkbox"/> Tarry (black) stools          | <input type="checkbox"/> Appendicitis               |
| <input type="checkbox"/> Laxatives       | <input type="checkbox"/> Food allergies or intolerance | <input type="checkbox"/> Heartburn                  |
| <input type="checkbox"/> Use of antacids | <input type="checkbox"/> Irregularity                  | <input type="checkbox"/> Pain before or after meals |

**KIDNEY/BLADDER**

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Kidney/bladder infection | <input type="checkbox"/> Bleeding        | <input type="checkbox"/> Pain or burning on urination |
| <input type="checkbox"/> Frequent voiding         | <input type="checkbox"/> Bladder trouble | <input type="checkbox"/> Stones                       |
| <input type="checkbox"/> Syphilis                 | <input type="checkbox"/> Gonorrhea       | <input type="checkbox"/> Hydrocele                    |
| <input type="checkbox"/> Nephritis                | <input type="checkbox"/> Discharge       | <input type="checkbox"/> Strictures                   |
| <input type="checkbox"/> Incontinence             | <input type="checkbox"/> Obstruction     |   |

Urinating at night, number of times per night \_\_\_\_\_

Provider initial: \_\_\_\_\_

**GYNECOLOGICAL:**

Could you be pregnant now?  Yes  No Date of last period \_\_\_\_\_

Number of pregnancies \_\_\_\_\_ Live births \_\_\_\_\_

Menstrual History: Age of onset \_\_\_\_\_ Frequency \_\_\_\_\_ Duration \_\_\_\_\_

Menopause (change of life)  Yes  No Age \_\_\_\_\_

Any bleeding or spotting since menopause? \_\_\_\_\_

**BONE MARROW:**

Anemia  Bleeding or bruising tendencies  Radiation

Benzene or other exposure? \_\_\_\_\_

**NEUROMUSCULAR: (provide details below)**

Headaches  Visual disturbances  Dizziness

Blackouts  Paralysis  Strokes

Forgetfulness  Head injury  Numbness

Convulsions  Epilepsy  Back pain

Sciatica  Neck pain or injury  Arthritis

Ruptured muscles  Torn ligaments  Trick knees

Severe/recurrent sprains  Rheumatism  Gout

Phlebitis  Partial or complete amputations

Pain or cramps when walking

**PSYCHIATRIC PROBLEMS:**

Nervous breakdown  Severe anxiety  Depression

Suicidal  Other \_\_\_\_\_

Comments/explanations:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Provider signature: \_\_\_\_\_

MD,  PA,  NP.