NEW PATIENT MEDICAL HISTORY

NAME:_____DOB:_____AGE:_____
SEX:_____

HOW DID YOU HEAR ABOUT OUR PRACTICE?

BRIEFLY STATE THE REASON FOR YOUR VISIT:

PAST MEDICAL HISTORY

DO YOU HAVE A HISTORY OF ANY OF THE FOLLOWING- if YES- write year it began/diagnosed:	List any other medical conditions and year:
❑ High blood pressure _____ ❑ High cholesterol_____ ❑ Hypothyroidism_____ ❑ Diabetes _____ ❑ COPD/Emphysema/Asthma _____ ❑ Gastro-reflux (GERD) _____ ❑ Depression or anxiety _____ ❑ Heart problems _____ ❑ Cancer_____ ❑ Blood disorder_____	_____ _____ _____ _____

PAST SURGICAL HISTORY/PROCEDURES/HOSPITALIZATIONS/SERIOUS INJURIES

Operation/Injury	Year	Operation/Injury	Year

Have you ever had a blood transfusion? Yes/NO

MEDICATION/FOOD ALLERGY

MEDICATION/FOOD	REACTION	MEDICATION/FOOD	REACTION

MEDICATIONS/SUPPLEMENTS					
MEDICATION/ SUPPLEMENT	DOSE	FREQUENCY	MEDICATION/FOOD	DOSE	FREQUENCY

SOCIAL/EDUCATIONAL/WORK HISTORY			
MARITAL STATUS:	Single/Married/Divorced/Widow	# of CHILDREN	
WORK STATUS:	Employed/Disabled/Retired	Current Occupation:	
Alcohol Use #of Years:_____	# of drinks per day?_____ If you quit-when?_____	Tobacco Use: # of yrs:_____	# of packs/day:_____ If you quit-when?_____
E-Cigs/Vape #of Years:_____	How often?_____ If you quit-when?_____	Recreational Drugs	List all:

Have you ever given yourself street drugs with a needle? YES/NO Date of last use:_____

Are you concerned you may have been exposed to HIV? YES/NO

FEMALES ONLY: ***You MUST inform Kroll Care PC if you are pregnant before taking Narcotics*****

Are you pregnant? YES/NO Date of LMP:_____ Year of Menopause:_____

FAMILY HISTORY

List family member with following conditions:

- ❑ High blood pressure _____
- ❑ High cholesterol_____
- ❑ Hypothyroidism_____
- ❑ Diabetes _____
- ❑ COPD/Emphysema/Asthma _____
- ❑ Gastro-reflux (GERD) _____
- ❑ Depression or anxiety _____
- ❑ Heart problems _____
- ❑ Cancer_____
- ❑ Blood disorder_____

List any other conditions in the below family members:

Father:_____

Mother:_____

Siblings:_____

NAME:_____DOB:_____

REVIEW OF SYSTEMS/SYMPTOMS	
CHECK ALL THAT YOU CURRENTLY HAVE OR HAVE HAD IN THE PAST 6 MONTHS:	
CONSTITUTIONAL ❑ Chills ❑ Fever ❑ Weight gain/loss ❑ Fatigue	PSYCHIATRIC ❑ Behavioral changes ❑ Anxiety ❑ Depression ❑ Memory loss ❑ Nervousness ❑ Mood changes
HEAD ❑ Dizziness ❑ Fainting ❑ Headaches/migraines ❑ History of head injury	SKIN ❑ Skin dryness ❑ Easy bruising ❑ Eczema ❑ Hives ❑ Rashes
Eyes/ENT ❑ Blurry vision ❑ Glaucoma ❑ Vision changes ❑ Ear problems ❑ Mouth problems ❑ Throat lumps/tenderness	NEUROLOGICAL ❑ Blackouts ❑ Fainting ❑ Paralysis ❑ Burning/tingling ❑ Tremors ❑ Unsteady gait ❑ History of falls
RESPIRATORY ❑ Asthma ❑ Bronchitis ❑ Shortness of breath ❑ Wheezing	ENDOCRINE ❑ Excess urination ❑ Diabetes ❑ Thyroid issues
CARDIOVASCULAR ❑ Chest pain ❑ High blood pressure ❑ Palpitations ❑ Swelling in legs ❑ LEG PAIN ❑ Heart murmur ❑ Ulcers on leg ❑ LAST EKG:_____	HEMATOLOGY ❑ Anemia ❑ Blood clots
GI ❑ Abdominal pain ❑ Decreased appetite ❑ Nausea ❑ Diarrhea ❑ Gallbladder disease ❑ Blood in stool ❑ Vomiting ❑ Constipation ❑ Liver disease	ALLERGIES ❑ Itchy eyes ❑ Runny nose ❑ Watery eyes ❑ Sneezing ❑ Sinus infections ❑ Wheezing with exercise

I understand this information is used to guide my treatment and I confirm it is accurate. Pt initials:_____