Paul A. Pannozzo, M.D., FAAPM&R Board Certified in PM&R and Pain Medicine

New Patient Health Information Sheet

Name: _____ Date: _____

Primary Care Doctor_____ Referring Doctor: _____

Past Medical History (Please circle answers)

Diabetes -- High Blood Pressure -- Heart Attack – TIA/Stroke – Heart Failure – Asthma – COPD – Ulcer – Cancer

Other Explain: _____

Past Surgical History (List operations you have had and dates, if known)

_____

_____

_____

Medications (List all medications currently taking and dose, if known)

_____

_____

_____

_____

Drug Allergies (List any medication allergies or intolerances and reactions)

_____

_____

Social History (Please circle answers)

Single -- Married – Divorced – Widowed – Committed Relationship

Occupation: _____ Are you currently working? Y / N □ Full Time □ Part time

Do you smoke? Y / N If yes, how many packs per day? _____ At what age did you begin smoking? ____

Do you drink alcohol? If yes, how often you drink? _____

Do you use, or have you used, illicit substances? _____

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Family History (Do family members have medical problems similar to yours? If yes, who?)

_____

_____

Review of Systems

General	None -- Weight change -- Fevers – Chills – Nausea – Fatigue
Cardiac	None – Chest pain – Palpitations – Murmur – Arrhythmia
Respiratory	None – Shortness of breath – Cough – Pneumonia – Fibrosis
Neurological	None – Numbness – Weakness – Blurry vision – Tremor – Other
Infectious Disease	None – Tuberculosis – Hepatitis – HIV – Other
Gastro-Intestinal	None – Ulcers – Reflux – Incontinence – Vomiting – Diarrhea – Constipation
Genito-Urinary	None – Renal failure – Nephritis – Blood in urine – Incontinence – Painful urination
Endocrine	None – Heat intolerance – Cold intolerance – Excessive thirst – Excessive urination
Hematological	None – Anemia – Clotting disorder – Leukemia – Hemaglobin abnormality
Skin	None – Rashes – Persistent Itch – Nail changes – Dry skin – Hair loss
Psychiatric	None – Depression – Bipolar Disorder – Anxiety Disorder – Suicidal Ideation
OB-GYN	None – Endometriosis – Heavy periods – Ovarian cysts
	Is there a chance you may be pregnant at this time? Y N
	Are you currently taking birth control pills? Y N
	Date of last menstrual period: _____

Is there anything else you would like the doctor to know about you?

_____

_____

_____

_____

Name: _____Date: _____