

New Patient Comprehensive History Form

Fox and Brantley Internal Medicine
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Confidential Record: Information contained here will not be released except when you have authorized us to do so.

Demographic Information

Last Name _____ First _____ Middle _____

DOB ____/____/____ Email _____

Street address _____

City _____ State _____ Zip code _____

Home Phone _____ Work Phone _____ Cell Phone _____

Emergency Contact: Name _____

Relationship to you _____

Home Phone _____ Work Phone _____

May we discuss routine lab results with someone else in your home if you are not there?

Y/N If so, whom? _____

Prior physician or referring physician _____

Date of last office visit there _____

How did you hear about our practice? _____

What is the reason for today's visit? _____

Please list the issues you want to discuss with your doctor.

Patient Name: _____ DOB: _____

Personal Information

Birth place _____ Education level _____

Occupation _____ Marital or relationship status _____

Describe religious or spiritual support _____

Do you have an advanced directive or living will? _____

Do you have a Health Care Power of Attorney? Y/N If so, who have you designated?

Name _____

Contact information _____

Past Medical, Surgical, and Psychological History

Please describe or list medical illnesses that you have or for which you have been treated:

List any operations you have had:

Describe any psychological (mental health) conditions for which you have received treatment or assistance (e.g.: medications, counseling, hospitalizations):

List date and reason for all prior hospitalizations:

Describe serious injuries or accidents that you have had:

Medications: List current medications and dosage, including over-the-counter medications and supplements:

| Medication | Dose | Frequency |
|------------|------|-----------|
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Do you have any medication or food allergies? **Y / N** If Yes, please list and describe the reaction _____

For Women:

Date of last Pap smear ____/____/____ Result: Normal ____ Abnormal ____

If you have ever had an abnormal result, please describe: _____

Date of last mammogram ____/____/____ Result: Normal ____ Abnormal ____

If you have ever had an abnormal result, please describe: _____

Patient Name: _____ DOB: _____

For Men:

Have you discussed prostate cancer screening with a doctor? **Y/ N**

Have you had a prostate blood test (PSA) in the past? **Y/ N**

If you have ever had abnormal result, please describe: _____

For Men and Women:

Have you had a colonoscopy for colon cancer screening? **Y/ N** If yes, date: _____

Results _____

What is your cholesterol level? Total _____ LDL _____ HDL _____ unknown _____

Have you had x-ray or radiation treatments, other than for treating cancer? **Y/ N**

Have you ever had high blood pressure? **Y/ N** If yes, describe: _____

**Immunizations:
Please list the date(s) of your immunizations**

| | | |
|--------------|--------------|-----------|
| Tetanus: | Pneumovax: | Zostavax: |
| Hepatitis A: | Hepatitis B: | Other: |

Family Health History:

Because some names may be used for either men or women, please indicate the sex of each brother, sister, son, or daughter

| Family Member | If Living | | | If Deceased | |
|------------------|-----------|-----|--------|--------------|----------------|
| | Sex | Age | Health | Age of death | Cause of death |
| Father | M/F | | | | |
| Mother | M/F | | | | |
| Brothers/Sisters | M/F | | | | |
| | M/F | | | | |
| | M/F | | | | |
| Husband/Wife | | | | | |
| Sons/Daughters | M/F | | | | |
| | M/F | | | | |
| | M/F | | | | |

Please list any relative (parent or sibling) who has or had the following illnesses:

Cancer: Breast _____ Prostate _____ Other _____
 Colon _____ age(s) _____ Colon Polyp _____ Type _____
(if known)

Vascular: High Blood Pressure _____ High Cholesterol _____
 Stroke _____ Other _____

Early Heart Attack: Any heart attacks or bypass/stent surgery younger than age 65?

Y / N Who? _____

Mental Health:

Depression _____ Alcoholism _____

Drug addictions _____ Suicide _____ Other _____

Hormonal: Diabetes _____ Thyroid _____

Osteoporosis _____ Other _____

Other: TB _____ Bleeding tendency _____

Personal Health Habits:

Do you wear seat belts regularly? **Y / N**

Do you exercise regularly (three times a week) **Y / N** Describe _____

Do you follow a particular nutritional plan? **Y / N**

Low fat ___ Low salt ___ High fiber ___ Vegetarian ___ Diabetic diet ___ Other ___

How stressful is your life? (circle the number that indicates your stress level)

1 2 3 4 5 6 7 8 9 10
(not stressful) _____ (very stressful)

List the stressors: _____

Do you cope with stress? **Y / N** How? _____

Do you currently smoke regularly? **Y/ N**

Cigarettes _____ Pipe _____ Cigars _____ How many packs daily? _____

How many years have you smoked tobacco? _____

If you quit tobacco, what year did you quit? _____

For how many years did you smoke? _____ How many packs daily? _____

Do you chew tobacco? **Y/ N** How much? _____

Do you drink sodas regularly? **Y / N** If yes, how many daily? _____

Do you drink alcohol **Y / N** If yes please describe what you drink and how much? _____

Do you ever feel like you need to cut down on your alcohol? **Y / N**

Do you ever feel angry or upset when other people talk to you about drinking? **Y / N**

Do you ever drink alcohol in the morning? **Y / N**

Patient Name: _____ DOB: _____

Do you feel guilty about your drinking? Y / N

Do you feel sad often? Y / N

Have you noticed that you have lost interest in things you enjoyed in the past? Y / N

Please describe _____

Review of Systems:

Please circle the symptoms that you have regularly or that have been present in the last month:

| GENERAL | HEENT | ENDOCRINE | CARDIOPULMONARY |
|---|--|---|---|
| Headaches Skin Rash Skin Sores Fatigue Fever Loss of appetite | Vision Decreased hearing Ringing in ears Dizziness Problems with teeth Sinus problems Hoarseness | Thyroid problems High blood sugar Increased thirst Increased urination | Chest pain Shortness of breath Palpitations Fainting spells Leg swelling Wheezing Cough |
| GASTROINTESTINAL | URINARY | MUSCULOSKELETAL | NEUROLOGICAL |
| Loss of appetite Abdominal pain Nausea or vomiting Constipation Diarrhea Hemorrhoids Blood in stools Problems swallowing | Painful urination Blood in urine Kidney stones Problems urinating Leakage of urine Frequent urination Urgent urination Sexual dysfunction | Arthritis Pain in joints Back pain | Seizures Tremors or shakes Numbness in hands Numbness in feet Weakness Stroke Memory problems |

Patient Name: _____ DOB: _____