NAME: _____ **NEW PATIENT MEDICAL HISTORY**

PATIENT INFORMATION

LAST NAME	FIRST NAME	MIDDLE INITIAL	SOCIAL SECURITY NUMBER

ADDRESS	CITY	STATE	ZIP
		TX	

HOME PHONE	CELL PHONE	DATE OF BIRTH	MARITAL STATUS
			Single

GENDER	E-MAIL ADDRESS	RACE
◯ Female; ◯ Male		◯ African American; ◯ Asian; ◯ Hispanic; ◯ White

EMERGENCY CONTACT (not living with you)	RELATIONSHIP	EMERGENCY CONTACT PHONE NO.
	Brother	

IS THE PATIENT'S PRIMARY LANGUAGE SPOKEN ENGLISH?

◯ Yes; ◯ No – Please review the NON-ENGLISH SPEAKING PATIENTS

COMMUNICATION PREFERENCE – CHOOSE ONE (REQUIRED)

◯ Letter; ◯ Cell Phone; ◯ Home Phone; ◯ Work Phone; ◯ E-Mail

Please note: We call to remind you of your appointments.
Please make sure to include a working telephone number.

PRIMARY CARE/FAMILY PHYSICIAN

PLEASE ATTACH CARD

PHYSICIAN NAME (required) – Please do not list Physician Assistant (PA) or Nurse Practitioners – Only list physicians (MD)

EMPLOYMENT INFORMATION

EMPLOYMENT STATUS

◯ Full Time; ◯ Part Time; ◯ Unemployed; ◯ Self Employed; ◯ Retired; ◯ Active Military; ◯ Other

EMPLOYER'S NAME	OCCUPATION

COMPLETE MAILING ADDRESS (including city, state, zip)	WORK PHONE + EXTENSION
	Extension

INSURANCE POLICYHOLDER INFORMATION

LAST NAME	FIRST NAME	MIDDLE INITIAL	RELATIONSHIP TO PATIENT
			Self

ADDRESS	CITY	STATE	ZIP
		TX	

HOME PHONE	CELL PHONE	SOCIAL SECURITY NUMBER	DATE OF BIRTH

GENDER	OCCUPATION	WORK PHONE + EXTENSION
◯ Female; ◯ Male		Extension

EMPLOYER'S NAME	COMPLETE ADDRESS (including city, state, zip)

INSURANCE PLAN(S)

PRIMARY INSURANCE	PRIMARY POLICYHOLDER
	◯ Pt; ◯ Sp; ◯ _____

SECONDARY INSURANCE	SECONDARY POLICYHOLDER
	◯ Pt; ◯ Sp; ◯ _____

Pt = Patient; Sp = Spouse

NAME: _____ **NEW PATIENT MEDICAL HISTORY**

PATIENT NAME	WHO REFERRED YOU TO US ◯ Friend; ◯ Relative; ◯ Dr.	◯ Female ◯ Male

PRIMARY CARE/FAMILY PHYSICIAN	PHYSICIAN PHONE NUMBER

PRIMARY CARE/FAMILY PHYSICIAN ADDRESS	CITY	STATE	ZIP
		TX	

CHIEF COMPLAINT

PLEASE SELECT ANY PROBLEM LISTED BELOW THAT IS CURRENTLY AFFECTING YOUR HEALTH.

☐ Back Pain	☐ Disease Flare	☐ Excessive Thirst	☐ Facial Rash
☐ Fatigue	☐ Insomnia	☐ Joint Pain/Stiff/Tender	☐ Limited Mobility
☐ Muscle Cramps	☐ Neck Pain	☐ Numbness	☐ Sensitivity to Cold
☐ Sensitivity to Pain	☐ Skin Rash	☐ Swollen Joints	☐ Other

ADDITIONAL COMPLAINT (please be very specific)

PRESENT MEDICATIONS

LIST ANY MEDICATIONS THAT YOU ARE CURRENTLY TAKING. INCLUDE PRESCRIPTION AND NON-PRESCRIPTION MEDICATIONS. IF YOU NEED ADDITIONAL SPACE, PLEASE ATTACH ANOTHER SHEET.

MEDICATION NAME	STRENGTH & DAILY DOSAGE	HOW LONG HAVE YOU TAKEN THIS MEDICATION	PRESCRIBING PHYSICIAN

PAST MEDICATIONS

LIST ANY MEDICATIONS THAT YOU HAVE TRIED IN THE PAST. AS ACCURATELY AS POSSIBLE, TRY TO COMPLETE THE TABLE BELOW.

MEDICATION NAME	STRENGTH & DAILY DOSAGE	PRESCRIBING PHYSICIAN	REACTION(S)

DRUG ALLERGIES

LIST ALL OF THE PATIENT'S DRUG ALLERGIES.

PAST/CURRENT MEDICAL CONDITIONS & FAMILY HISTORY

SELECT ALL THE PATIENT'S PAST AND CURRENT MEDICAL CONDITIONS BY PLACING A CHECK IN THE PATIENT COLUMN.
SELECT ALL THE MEDICAL ISSUES RELATED TO THEIR FAMILY BY PLACING A CHECK IN THE APPROPRIATE COLUMN(S).

		PATIENT	FATHER	MOTHER	BROTHER	SISTER
Acid Reflux/GERD	[M: 266997008; F: 160381001]	☐	☐	☐	☐	☐
Alcoholism	[M: 371434005; F: 266890009]	☐	☐	☐	☐	☐
Anemia/Bleeding/Clotting Disorders	[M: 266992002; F: 160316001]	☐	☐	☐	☐	☐
Ankylosing Spondylitis	[M: 267004000; F: 266907002]	☐	☐	☐	☐	☐
Antiphospholipid Syndrome	[M: 266992002; F: 160316001]	☐	☐	☐	☐	☐
Anxiety/Depression	[M: 161464003; F: 160324006]	☐	☐	☐	☐	☐
Arthritis	[M: 275554004; F: 275134007]	☐	☐	☐	☐	☐
Asthma/Allergy	[M: 161523006; F: 266898002]	☐	☐	☐	☐	☐
Bone/Joint Injuries	[M: 267004000; F: 266907002]	☐	☐	☐	☐	☐
Broken/Fractured Bones	[M: 267004000; F: 266907002]	☐	☐	☐	☐	☐
Cancer	[M: 266987004; F: 275937001]	☐	☐	☐	☐	☐
Carpal Tunnel Syndrome	[M: 267574006; F: 297239000]	☐	☐	☐	☐	☐
Cataracts	[M: 267574006; F: 160346003]	☐	☐	☐	☐	☐
Connective Tissue Disorders	[M: 267004000; F: 266907002]	☐	☐	☐	☐	☐
Coronary Artery Disease (Heart Disease)	[M: 266995000; F: 266894000]	☐	☐	☐	☐	☐
Crohn's Disease	[M: 266997008; F: 160381001]	☐	☐	☐	☐	☐
Diabetes	[M: 266990005; F: 160303001]	☐	☐	☐	☐	☐
Ehlers-Danlos Syndrome	[M: 267004000; F: 266907002]	☐	☐	☐	☐	☐
Fibromyalgia	[M: 267004000; F: 266907002]	☐	☐	☐	☐	☐
Gastrointestinal Disease	[M: 266997008; F: 160381001]	☐	☐	☐	☐	☐
Glaucoma	[M: 267574006; F: 160347007]	☐	☐	☐	☐	☐
Gout/Pseudogout	[M: 267004000; F: 266907002]	☐	☐	☐	☐	☐
Hearing Problems	[M: 267574006; F: 439750006]	☐	☐	☐	☐	☐
Hyperlipidemia (High Cholesterol)	[M: 266995000; F: 266887003]	☐	☐	☐	☐	☐
Hypertension (High Blood Pressure)	[M: 266995000; F: 160357008]	☐	☐	☐	☐	☐
Juvenile Rheumatoid Arthritis	[M: 267004000; F: 266907002]	☐	☐	☐	☐	☐
Kidney Disease	[M: 267002001; F: 289916006]	☐	☐	☐	☐	☐
Liver Disease/Hepatitis	[M: 266997008; F: 160381001]	☐	☐	☐	☐	☐
Lupus/SLE	[M: 267004000; F: 266907002]	☐	☐	☐	☐	☐

PAST/CURRENT MEDICAL CONDITIONS & FAMILY HISTORY (continued)

SELECT ALL THE PATIENT'S PAST AND CURRENT MEDICAL CONDITIONS BY PLACING A CHECK IN THE PATIENT COLUMN.
SELECT ALL THE MEDICAL ISSUES RELATED TO THEIR FAMILY BY PLACING A CHECK IN THE APPROPRIATE COLUMN(S).

		PATIENT	FATHER	MOTHER	BROTHER	SISTER
Multiple Sclerosis (MS)	[M: 267574006; F: 297239000]	☐	☐	☐	☐	☐
Neuropathy/Polyneuropathy	[M: 267574006; F: 297239000]	☐	☐	☐	☐	☐
Obesity/Eating Disorder	[M: 266990005; F: 160305008]	☐	☐	☐	☐	☐
Osteoarthritis	[M: 267004000; F: 266907002]	☐	☐	☐	☐	☐
Osteoporosis	[M: 267004000; F: 160313009]	☐	☐	☐	☐	☐
Parkinson's Disease	[M: 267574006; F: 297239000]	☐	☐	☐	☐	☐
Pneumonia	[M: 161523006; F: 266898002]	☐	☐	☐	☐	☐
Polymyalgia Rheumatica	[M: 267004000; F: 266907002]	☐	☐	☐	☐	☐
Psoriasis/Psoriatic Arthritis	[M: 161560005; F: 160406008]	☐	☐	☐	☐	☐
Psychiatric Conditions	[M: 161464003; F: 160324006]	☐	☐	☐	☐	☐
Pulmonary Fibrosis	[M: 161523006; F: 266898002]	☐	☐	☐	☐	☐
Radiculopathy	[M: 267574006; F: 297239000]	☐	☐	☐	☐	☐
Raynaud's Syndrome	[M: 266995000; F: 266894000]	☐	☐	☐	☐	☐
Reflex Sympathetic Dystrophy	[M: 267004000; F: 266907002]	☐	☐	☐	☐	☐
Reiter's Disease	[M: 267004000; F: 266907002]	☐	☐	☐	☐	☐
Rheumatic Fever	[M: 161413004; F: 160279000]	☐	☐	☐	☐	☐
Rheumatoid Arthritis	[M: 267004000; F: 266907002]	☐	☐	☐	☐	☐
Scleroderma	[M: 161560005; F: 160406008]	☐	☐	☐	☐	☐
Scoliosis	[M: 267004000; F: 266907002]	☐	☐	☐	☐	☐
Seizure/Epilepsy	[M: 267574006; F: 297239000]	☐	☐	☐	☐	☐
Sjogren's Syndrome	[M: 267004000; F: 266907002]	☐	☐	☐	☐	☐
Skin Problems/Eczema	[M: 161560005; F: 160406008]	☐	☐	☐	☐	☐
Spinal Stenosis	[M: 267004000; F: 266907002]	☐	☐	☐	☐	☐
Stroke	[M: 267574006; F: 275104002]	☐	☐	☐	☐	☐
Substance Abuse	[M: 371435006; F: 134591000119102]	☐	☐	☐	☐	☐
Thyroid Problems	[M: 266990005; F: 160302006]	☐	☐	☐	☐	☐
Trigger Finger	[M: 267004000; F: 266907002]	☐	☐	☐	☐	☐
Tuberculosis	[M: 161523006; F: 266898002]	☐	☐	☐	☐	☐
Ulcerative Colitis	[M: 266997008; F: 160381001]	☐	☐	☐	☐	☐
Vasculitis	[M: 266995000; F: 266894000]	☐	☐	☐	☐	☐
Vision Problems	[M: 267574006; F: 160346003]	☐	☐	☐	☐	☐
Other:		☐	☐	☐	☐	☐

SURGERIES/PROCEDURES

[M: 161615003]

SELECT ALL THE SURGERIES/INVASIVE PROCEDURES THE PATIENT HAS EVER HAD:

☐ Other Abdominal Surgery ☐ Angioplasty ☐ Back Surgery ☐ Breast Surgery
☐ Other Cardiac Surgery ☐ Cosmetic Surgery ☐ Eye Surgery ☐ Gallbladder Surgery
☐ Hernia Repair ☐ Joint Replacement ☐ Neurosurgery ☐ Other Orthopedic Surgery
☐ Weight Loss Surgery ☐ None ☐ Other

SMOKING HISTORY

HAS THE PATIENT EVER SMOKED DURING THEIR LIFETIME?	HOW MANY CIGARETTES DOES THE PATIENT SMOKE PER DAY?
◯ No, skip these questions; ◯ Yes, continue	◯ Less than 1 pack; ◯ 1-2 packs; ◯ 2 or more packs
HOW MANY YEARS HAS THE PATIENT SMOKED?	**HOW MANY YEARS DID THE PATIENT PREVIOUSLY SMOKE?**
◯ Less than 1 yr; ◯ 1-5 yrs; ◯ 5-10 yrs; ◯ 10+ yrs	◯ Less than 1 yr; ◯ 1-5 yrs; ◯ 5-10 yrs; ◯ 10+ yrs

SLEEPING HABITS

SELECT ALL OF THE FOLLOWING SLEEPING HABITS THE PATIENT IS EXPERIENCING:

☐ Difficulty falling asleep ☐ Continuity disturbances ☐ Snoring
☐ Early morning awakening ☐ Daytime drowsiness ☐ Other:

DOES THE PATIENT WAKE UP FEELING RESTED?

◯ Yes
◯ No

LIVING SITUATION

DOES THE PATIENT LIVE IN A(N):

◯ Apartment ◯ Assisted Living ◯ Nursing Home ◯ Private Home ◯ Other

HEALTH ASSESSMENT QUESTIONNAIRE – DISABILITY INDEX

Are you able to:	Without ANY Difficulty 0	With SOME Difficulty 1	With MUCH Difficulty 2	UNABLE To Do 3	OFFICE USE ONLY
DRESSING & GROOMING					
1. Dress yourself, including tying shoelaces and doing buttons?	◯	◯	◯	◯	
2. Shampoo you hair?	◯	◯	◯	◯	
ARISING					+
3. Stand up from a straight chair?	◯	◯	◯	◯	
4. Get in and out of bed?	◯	◯	◯	◯	
EATING					+
5. Cut your own meat?	◯	◯	◯	◯	
6. Lift a full cup or glass to your mouth?	◯	◯	◯	◯	
7. Open a new milk carton?	◯	◯	◯	◯	
WALKING					+
8. Walk outdoors on flat ground?	◯	◯	◯	◯	
9. Climb up five (5) steps?	◯	◯	◯	◯	
HYGIENE					+
10. Wash and dry your body?	◯	◯	◯	◯	
11. Take a tub bath, if desired?	◯	◯	◯	◯	
12. Get on and off the toilet?	◯	◯	◯	◯	
REACH					+
13. Reach and get a 5-pound object from just above your head?	◯	◯	◯	◯	
14. Bend down and pick up clothing from the floor?	◯	◯	◯	◯	
GRIP					+
15. Open car doors?	◯	◯	◯	◯	
16. Open jars which have been previously opened?	◯	◯	◯	◯	
17. Turn faucets on and off?	◯	◯	◯	◯	

Health Assessment Questionnaire – Disability Index (continued)

Are you able to:	Without ANY Difficulty 0	With SOME Difficulty 1	With MUCH Difficulty 2	UNABLE To Do 3
ACTIVITIES				
18. Run errands and shop?	○	○	○	○
19. Get in and out of a car?	○	○	○	○
20. Do chores such as vacuuming or yard work?	○	○	○	○

OFFICE USE ONLY

\+ [ ]

= [ ]

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= [ ]

Mark any AIDS or DEVICES that you usually use for any of these activities:

- ☐ Bathtub Bar
- ☐ Bathtub Seat
- ☐ Built-Up/Special Utensils
- ☐ Cane
- ☐ Crutches
- ☐ Dressing Devices (button hook, zipper pull, long shoehorn, etc).
- ☐ Jar Opener (for previously opened jars)
- ☐ Long-Handled Appliances for Reach
- ☐ Long-Handled Appliances in Bathroom
- ☐ Raised Toilet Seat
- ☐ Special/Built-Up Chair
- ☐ Walker
- ☐ Wheelchair

YOUR HAQ SCORE →

Mark any categories for which you usually need HELP FROM ANOTHER PERSON:

- ☐ Arising
- ☐ Dressing & Grooming
- ☐ Gripping & Opening Things
- ☐ Eating
- ☐ Errands
- ☐ Hygiene
- ☐ Reaching
- ☐ Walking

We are also interested in learning whether or not you are affected by pain because of your illness.

YOUR ACTIVITIES: To what extent are you able to carry out your everyday physical activities such as walking, climbing stairs, carrying groceries, or moving a chair?

○ Completely ○ Mostly ○ Moderately ○ A Little ○ Not At All

YOUR PAIN: How much pain have you had in the past week? Record the number below.
0 = No Pain to 100 = Severe Pain ____ ____ ____

YOUR HEALTH: Rate how well you are doing. Record the number below.
0 = Very Poor to 100 = Very Well ____ ____ ____

← FOR OFFICE USE ONLY - - - FOR OFFICE USE ONLY - - - FOR OFFICE USE ONLY →

FOR PHYSICIAN ONLY ****DO NOT COPY****

PHYSICIAN'S GLOBAL ASSESSMENT: Make an " | " on the line below to indicate the activity, independently of the patient's self assessment.

VERY GOOD ——————————— **VERY BAD**

MEASUREMENT [ ] [ ] [ ]

REVIEW OF SYSTEMS

MARK ANY THAT APPLY TO THE PATIENT.

Constitutional

- ☐ Change in Appetite
- ☐ Change in Weight
- ☐ Chills
- ☐ Edema
- ☐ Fatigue
- ☐ Fever
- ☐ Insomnia (difficulty sleeping)
- ☐ Night Sweats
- ☐ Weakness

Other:

EYES

- ☐ Double Vision
- ☐ Dry Eyes
- ☐ Eye Pain
- ☐ Feeling of Something in Eyes
- ☐ Loss of Vision

Other:

EARS, NOSE, MOUTH, & THROAT

- ☐ Change in Appearance of Neck
- ☐ Difficulty with Balance
- ☐ Difficulty with Swallowing
- ☐ Dry Ears/Nose/Mouth/Throat
- ☐ Hearing Problems
- ☐ Injury to Head/Neck/Throat
- ☐ Lumps or Swollen Neck Glands
- ☐ Mouth Sores
- ☐ Neck Pain/Stiffness
- ☐ Sinus Problems

Other:

CARDIOVASCULAR

- ☐ Chest Pain
- ☐ Palpitations (heart fluttering)
- ☐ Shortness of Breath at Night
- ☐ Swollen Ankles / Legs

Other:

RESPIRATORY

- ☐ Coughing up Blood
- ☐ Frequent Cough
- ☐ Shortness of Breath
- ☐ Wheezing / Asthma

Other:

DIGESTIVE

- ☐ Abdominal Pain
- ☐ Black Stools
- ☐ Bloody Stools
- ☐ Colon Screening (colonoscopy)
- ☐ Constipation
- ☐ Diarrhea
- ☐ Gas
- ☐ Heartburn / GERD
- ☐ Indigestion
- ☐ Nausea / Vomiting

Other:

GENITOURINARY

- ☐ Blood in Urine
- ☐ Excessive Urination
- ☐ Painful Urination
- ☐ Trouble Urinating
- ☐ Vaginal Dryness

Other:

MUSCULOSKELETAL

- ☐ Back Pain
- ☐ Broken / Fractured Bones
- ☐ Muscle Cramps / Aches
- ☐ Stiffness
- ☐ Swollen / Tender Joints

Other:

SKIN

- ☐ Acne
- ☐ Breast Discharge
- ☐ Breast Tenderness
- ☐ Change in Complexion
- ☐ Change in Perspiration (sweat)
- ☐ Change in Skin Texture
- ☐ Color Change in Hands/Feet in Cold
- ☐ Hair Loss
- ☐ Lumps in Breast
- ☐ Rash ☐ Itching
- ☐ Sun Sensitivities

Other:

NEUROLOGICAL

- ☐ Change in Movement
- ☐ Dizziness
- ☐ Loss of Consciousness
- ☐ Memory Loss
- ☐ Numbness of Arms / Legs
- ☐ Poor Balance / Unsteady Walk
- ☐ Seizures
- ☐ Severe Headaches
- ☐ Tingling or Altered Sensations
- ☐ Tremors or Shaking

Other:

PSYCHIATRIC

- ☐ Confusion
- ☐ Previous Psychiatric Care
- ☐ Sad / Depressed
- ☐ Tense / Anxious
- ☐ Thoughts of Death

Other:

HORMONAL

- ☐ Change in Energy Level
- ☐ Change in Temperature Tolerance
- ☐ Frequent Thirst
- ☐ Frequent Urination ☐ at Night

Other:

HEMATOLOGIC/LYMPHATIC

- ☐ Easy Bruising
- ☐ Problems with Excessive Bleeding
- ☐ Swollen Glands

Other:

ALLERGIC/IMMUNOLOGIC

- ☐ Seasonal Allergies

Other:

Thank you for your interest in our office. Once this paperwork is completed, please return it to our office by fax or mail. After Dr. Anderle reviews it, our office will call to schedule an appointment.

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