Dr. Alger New Patient General History Form

ARBOR MEDICAL

To The Best of Your Ability - Please Check The Following

NAME: ______________________________ DATE: ______________

Address: ______________________________ D.O.B: ______________
______________________________ Sex: M F

Phone #: Home: ______________ Cell: ______________
Work: ______________ Email: ______________________

Referring Physician: ______________________
(If applicable) Phone: ______________
Primary Physician: ______________________
(If applicable) Phone: ______________

Pharmacy Name: ______________________
Address: ______________________
Phone #: ______________________

Drug Allergies: Y / N

Name of Drug	Reaction

CURRENT MEDICATIONS

Name	Dosage	Frequency

PAST MEDICAL HISTORY (Check all items that apply to you and fill in the blank as needed)

______	**Anemia**	______	**Hepatitis: please circle (A B C)**
______	**Arithritis**	______	**HIV / AIDS**
______	**Asthma**	______	**High Blood Pressure**
______	**Cancer and what type?**	______	**Thyroid: Please circle (High / Low)**
______	**Bowel Problems**	______	**Kidney Disease / Kidney Stones**
______	**COPD/Emphysema**	______	**Mental Illness / Depression**
______	**Diabetes**	______	**Heart Burn / Acid Reflux**
	Please cirlce type 1 or 2	______	**Sexually Transmitted Disease**
______	**Epilepsy**	______	**Sickle Cell Anemia/Trait**
______	**Hearing Loss**	______	**Skin disease (ezcema, psoriasis)**
______	**Heart disease**	______	**Stroke**

Other: ________________________________

PAST SURGICAL HISOTRY (Check all items that apply to you and fill in blanks as needed)

______	**Angioplasty**	______	**Hernia**
______	**Appendectomy**	______	**Hysterectomy**
______	**Breast Procedure R / L**	______	**Knee R / L**
______	**Gallbladder removal / gallstone remova**	______	**Fracture**

Other:_________________________________

FAMILY HISTORY

Any family history of colon / breast / ovarian / other cancer? Y / N Who?___________

Relationship	Illness
________________	____
________________	____
________________	____
________________	____
________________	____

To The Best of Your Ability - Please Check The Following

Personal Health Assessment

Personal Health Recommendations and Screenings	**Date Completed**
Do you have any advance care planning (Living Will)?	________
When was your last complete eye exam?	________
Have you had Osteoporosis screening/treatment (DEXA)?	________
Have you had a Colon cancer screening (Colonoscopy)?	________
Have you been tested for Hepatitis C?	________
(Date of birth 1945-1965 History of blood transfusion) History of intravenous drug use	
For Women, have you had any of the following?	
Mammogram	________
Pap smear	________
For Men, have you had any of the following?	
PSA (Prostate)	________
Have you been screened for an Abdominal Aortic Aneurism (AAA)?	________
(If you have a history of smoking.)	
Are you at risk for falls?	
Do you have a history of falls?	**Y / N**
Do you have a history of balance issues?	**Y / N**
Smoking	
Are you a current smoker?	**Y / N**
Do you have a history of smoking?	**Y / N**
If you are currently smoking, are you interested in a smoking cessation program?	**Y / N**
Have you had any lung cancer screening?	________
If you have Diabetes	
Have you had any testing for A1c or Cholesterol (LDL)?	________
Have you had a diabetic foot exam?	________

Do you feel guilty about drinking?	**Y**	**N**
Have you ever had a drink in the morning to calm your nerves?	**Y**	**N**

To The Best of Your Ability - Please Check The Following

Immunization Form

Have you had any of the following vaccines?

Date Completed

- ☐ Pneumonia
  - ☐ Prevnar 13 (Pneumococcal conjugate) ________________
  - ☐ Pneumovax 23 (Pneumococcal polysaccharide) ________________
- ☐ Infuenza (yearly) ________________
- ☐ Shingles (Zostavax) (once after age 65) ________________
- ☐ Shingrex ________________
- ☐ Tetanus/diptheria/pertussis (Tdap)(every 10 years) ________________
- ☐ Tetanus Booster ________________

***Patient has been advised to receive age appropriate vaccinations**

PHYSICIAN USE ONLY

- ☐ Pneumonia
  - ☐ Prevnar 13 (Pneumococcal conjugate)
  - ☐ Pneumovax 23 (Pneumococcal polysaccharide)
- ☐ Infuenza
- ☐ Shingles (Zostavax)
- ☐ Shingrex
- ☐ Tetanus/diptheria/pertussis (Tdap)
- ☐ Tetanus Booster

SOCIAL HISTORY

Do you exercise?	**Y / N**	How often?_______________
Are you sexually active? (OPTIONAL)	**Y / N**	
Have you been exposed to hazardous materials?	**Y / N**	
Are you on a special diet / vegetarian?	**Y / N**	

	Not at all	**Some Days**	**More than Half the Days**	**Nearly Every Day**
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	3
Trouble falling or staying asleep, or sleeping too much	0	1	2	3
Feeling tired or having little energy	0	1	2	3
Poor appetite or overeating	0	1	2	3
Feeling bad about yourself- or that you are a failure or have let your family down	0	1	2	3
Trouble concentrating on things such as reading the newspaper or watching television	0	1	2	3
Moving or speaking so slowly that other people could have noticed? Or the opposite- being so restless that you have been moving around more than usual	0	1	2	3
Thoughts that you would be better off dead or hurting yourself in some way	0	1	2	3

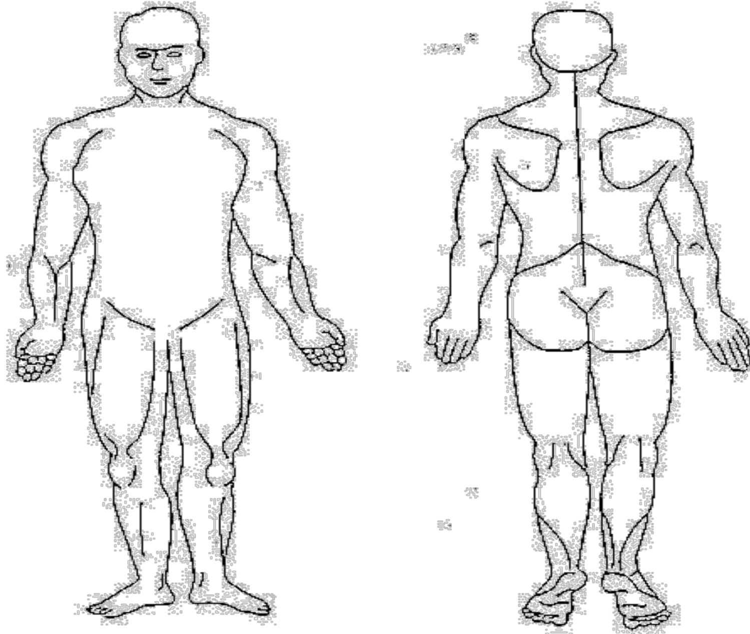
Total Score: _________________

How many times in the past year have you had 5 or more drinks in a day? ___________________

If you answered ONE or more to the previous question, please answer the following:

Do you get angry when others comment about your drinking?	**Y**	**N**
Are you concerned about your drinking?	**Y**	**N**
Do you feel guilty about drinking?	**Y**	**N**
Have you ever had a drink in the morning to calm your nerves?	**Y**	**N**

Where is your pain located? **2B**
Please shade the areas of your pain in the diagrams below.



When did your pain first start?

____

____

What do you think is causing your pain?

____

____

Did your pain begin with an injury? **Y** **N**

If yes, where did the injury occur? **Work** **Car** **Other:________________**

Please explain how you were injured:

____

____

Do you have a legal case pending regarding your pain? **Y** **N**

In the following questions, please rate your pain on a scale from 0 to 10:
(0= no pain, 10= worst pain you can ever imagine)

How severe is your pain at its worst?	0	1	2	3	4	5	6	7	8	9	10
How severe is your pain at its best?	0	1	2	3	4	5	6	7	8	9	10
What is your pain level today?	0	1	2	3	4	5	6	7	8	9	10

What does your pain feel like? (Please circle all that apply)

Throbbing	Sharp	Tender	Aching	Burning
Shooting	Tingling	Pressure	Cramping	
Stabbing	Numb	Deep	Heaviness	

What is the pattern of your pain? (Please circle all that apply)

Always present   Comes and Goes   Worsens as the day goes on

What makes your pain worse? (Please circle all that apply.)

Sitting	Twisting	Sneezing	Lying Down
Bending	Driving	Standing	Other: ________________________
Lifting	Coughing	Walking	

What makes your pain better? (Please circle all that apply.)

Rest	Bending	Medications	Heat
Lying Down	Sitting	Ice	Other: ____________________________

Does your pain make you feel (Please circle all that apply.):

Depressed	Angry	Frustrated	Helpless	Hopeless

Please check any previous treatment you have had for your current pain

Herabal remedies: **Y** **N** Any benefit? **Y** **N**

Physical or occupational therapy: **Y** **N** When was the last session? ___________________

How long did therapy last? **Y** **N** Any benefit? **Y** **N**

Chiropractor visit: **Y** **N** Any benefit? **Y** **N**

Injections: **Y** **N** Where? _________________________________

When? __________________________ Any benefit? **Y** **N**

Who did them? ____________________

Surgeries: **Y** **N** Any benefit? **Y** **N**

Biofeedback: **Y** **N** Any benefit? **Y** **N**

Accupuncture: **Y** **N** Any benefit? **Y** **N**

Have you had any tests performed related to your pain? (Please circle all that apply.)

Xray MRI CT Bone Scan

Blood Test EMG Myelogram

Please list all *PREVIOUS* pain medications you are taking along with dosage and frequency.
Please indicate if the medications help or not.

NAME	DOSAGE	FREQUENCY	HELPFUL	
________	________	________	**Y**	**N**
________	________	________	**Y**	**N**
________	________	________	**Y**	**N**
________	________	________	**Y**	**N**
________	________	________	**Y**	**N**

Are you currently taking blood thinner medications? **Y** **N**

WORK HISTORY
Are you currently working? **Y** **N**
If yes, who is your current employer? ________________________________

What is your occupation?____

Are you on disability? **Y** **N**
If yes, how long have you been disabled? ________________________________
What caused you to become disabled? ___________________________________

REVIEW OF SYSTEMS
Please circle any of the following problems you are currently experiencing:
Constitutional:

Weight change Weakness Fatigue Fever

Eyes, Nose, Throat:

Hearing Loss Diziness Ringing in Ears Sore Throat Nasal Congestion

Cardiovascular:

Shortness of breath Chest pain Palpitations Ankle Swelling

Gastrointestinal:

Heartburn Nausea Vomiting Abdominal Pain Constipation

Diarrhea Bowel Incontinence Bloody Stool

Genitourinary:

Pain with Urination Bladder Incontinence Urgency Blood in Urine

Musculoskeletal:

Joint Pain Stiffness Neck or back Pain

Skin:

Rash Lumps Itching Nail or Hair changes

Neurological:

Headache Weakness Numbness Seizures

Black Outs Memory loss

Psychological:

Nervousness Tension Depression Anxiety

Endocrine:

Heat or cold intolerance Sweating Hunger Thirst Change in urination

Hematologic:

Bruising Bleeding

Without your expressed and written consent, all medical information remains confidental

SIGNATURE OF PATIENT: ____

DATE: __________________________