NEW PATIENT HEALTH HISTORY
Osteopathic Wellness, 253 Main St, Yarmouth ME 04096

Name: _____ Age: _____

Primary Care Physician: _____

WHY ARE YOU HERE TODAY?

_____

CURRENT MEDICINES, SUPPLEMENTS, and HERBS (with DOSAGE please):

_____
_____
_____
_____

Date of last physical examination: _____ By whom? _____

ALLERGIES: _____

PAST MEDICAL HISTORY: List all major illnesses, injuries, traumas (including emotional), and surgeries

_____
_____
_____
_____

How many hours of Sleep do you get a night? _____

How many glasses of Water do you drink daily? _____ Coffee _____ Cola _____

How many Alcoholic beverages do you drink per day? _____

Do you Smoke? _____ If so, how much per day? _____ Have you ever smoked? _____ When Quit? _____

Do you use Drugs recreationally? _____ If so, what kind? _____

How much Exercise per week and what kind? _____

What do you do for Fun? _____

FAMILY MEDICAL HISTORY (medical illnesses your family members have):

Mother_____

Father _____

Siblings_____

Name: _____ Date of Birth: _____

REVIEW OF SYMPTOMS: Check off any of the following symptoms you have/had ***RECENTLY*** experienced within the last **ONE WEEK:**

GENERAL:
- ☐ weight change
- ☐ tired/weak
- ☐ dizzy/fainting
- ☐ fever/chills

HEAD:
- ☐ headaches
- ☐ glaucoma
- ☐ cataracts
- ☐ blurry vision
- ☐ hearing aids
- ☐ eye pain
- ☐ hearing loss
- ☐ noise in ears
- ☐ earaches
- ☐ voice change
- ☐ runny nose
- ☐ stuffy nose
- ☐ nosebleeds
- ☐ sore throats
- ☐ swollen glands
- ☐ painful teeth
- ☐ bleeding gums
- ☐ dentures
- ☐ goiter

RESPIRATORY:
☐ cough ☐ cough with phlegm ☐ cough with blood ☐ wheezing ☐ short of breath

HEART & CIRCLATION:
☐ high blood pressure ☐ heart races or skips beats ☐ chest pain ☐ short of breath after climbing steps
☐ short of breath while laying in bed ☐ legs swell ☐ legs hurt or cramp when walking ☐ varicose veins

DIGESTIVE:
☐ trouble swallowing ☐ heartburn ☐ poor appetite ☐ nausea ☐ vomiting (with blood?) ☐ abdominal pain
☐ diarrhea ☐ constipation ☐ excess belching or passing gas ☐ change in stool (with blood?)
☐ hemorrhoids ☐ rectal pain ☐ jaundice ☐ gallbladder pain

URINARY:
☐ burning with urination ☐ frequent urination ☐ change in urine stream (with blood?)
☐ frequent urinary infection ☐ lose urine if you cough or sneeze ☐ kidney stones

MUSCULOSKELETAL:
☐ pain in muscles or joints ☐ morning stiffness ☐ backache ☐ sciatica ☐ low back pain ☐ arthritis
☐ gout ☐ short leg ☐ wear a shoe lift ☐ scoliosis ☐ spondylolisthesis ☐ muscle spasms

NEUROLOGICAL:
☐ blackouts ☐ seizures ☐ numbness or loss of sensation ☐ tingling or "pins and needles"
☐ tremors or other involuntary movements ☐ weakness in arms or legs ☐ trouble walking

OTHER:
☐ heat or cold intolerance ☐ excessive sweating ☐ excessive thirst or hunger ☐ excessive urination
☐ nervousness ☐ tension ☐ depression ☐ difficulty with memory ☐ confusion ☐ skin changes / rash

MALE PATIENTS: ☐ urinary stream slower, smaller or split ☐ lumps or pain in testicles ☐ erection problems ☐ sores

FEMALE PATIENTS: Age your periods began: _____; Date of last period _____;

Number of pregnancies _____; Number of deliveries _____; Age at menopause: _____

Birth control method: _____

☐ Breast tenderness or pain ☐ breast lumps ☐ nipple discharge ____ hot flashes

☐ Abnormal menstrual cycle ☐ vaginal sores or discharge ☐ painful intercourse

Name: _____ **DOB:** _____

Chief Complaint TODAY: _____

On a scale of 0-10, 0 being no pain and 10 being the worst pain you have ever felt, what's your pain today? 10

Using the pain scale above, what is the WORST your pain gets on ANY day? 1

What helps your symptoms? _____

What worsens your symptoms? _____

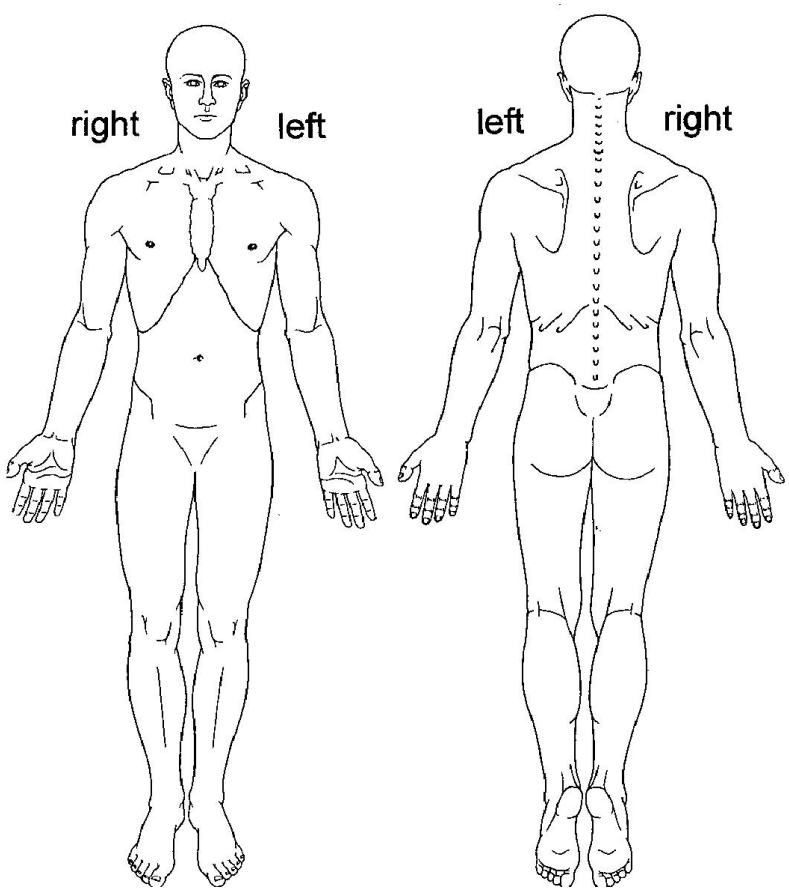
Please mark any of the following symptoms that you are experiencing:

☐ Abdominal Pain
☐ Bowel or bladder dysfunction
☐ Numbness or tingling of the arms or legs
☐ Weakness of the arms or legs
☐ Headaches

Any medication changes? If so, what? _____

PAIN PATTERNS: On the figures below please illustrate your areas of pain and/or numbness using the following key: Moderate Pain = o o o o o Severe Pain = x x x x x Numbness = N N N N N

Describe your pain: Achy, sharp, constant, intermittent, Other: _____



Provider Signature: _____ DOS: _____ Time: _____