

CPN New Patient History

Name: _____ Date of Birth: _____

Allergies: Medications and type of reaction: (may use other side if needed)

Current medications, doses, and frequency of both prescribed and over the counter. Please include all supplements and herbal drugs also.

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____
11. _____
12. _____
13. _____

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Past Medical History: Please list chronic medical conditions, illnesses, and hospitalizations (please include approximate dates if known):

Immunizations:

Date of last Flu shot:

Date of last pneumonia shot:

Date of last Tetanus shot:

Gynecologic:

Date of last menstrual period:

Age menses began:

Date of last Pap smear:

Name of Physician who performed pap:

Date of last Mammogram:

Who performed last mammogram:

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Diabetes:

Date of last diabetic eye exam:

Who performed last diabetic eye
exam: _____

Date of last diabetic foot exam:

Who performed last diabetic foot exam:

**Past Surgeries: List any and all you have had and please
include approximate dates:**

Date of Last colonoscopy:

Who performed last colonoscopy:

Family History:

Father: Living or deceased

Health problems: _____

Died at age _____

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Mother: Living or deceased

Health problems: _____

Died at age _____

Brothers or sisters and their health:

Other conditions that run in your family: _____

Social History: Marital Status: (circle one)

Married Single Divorced Separated Widowed Other

Number of children and their ages: _____

Number of pregnancies: _____

Your Occupation: _____

Spouse or Significant other's occupation: _____

Smoking history: (circle one)

Current Smoker Previous Smoker Never Smoked

If a current smoker or previous smoker, in what year did you start smoking? _____

What do you or did you smoke?

Cigarettes Cigars Pipe

Amount smoked per day?

If you quit smoking, in what year did you quit? _____

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Alcohol use: Do you drink alcoholic beverages? Yes No
If so, how many drinks do you have in a typical week?

What do you typically drink?

Do you use illegal drugs? Yes No
If so, what type

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Mark any of the following with a \checkmark that represent significant and on-going problems for you.

General:

- Fevers
- Chills
- Sweats
- Poor appetite
- Weight loss

Eyes:

- Blurred vision
- Double vision
- Irritation
- Discharge from eyes
- Vision loss
- Eye pain
- Extreme sensitivity to light

Ears/Nose/Throat:

- Earache
- Ear discharge
- Ringing in the ears
- decreased hearing
- Nasal congestion
- Nosebleeds
- Trouble Swallowing
- Hoarseness

Cardiovascular:

- Edema (swelling)
- Shortness of breath when lying flat
- Chest pains
- Skipping or racing heartbeats
- Fainting or passing out
- Shortness of breath with activity

Respiratory:

- Cough
- Shortness of breath
- Excessive sputum (phlegm)
- Coughing up blood
- Wheezing

Gastrointestinal:

- Nausea
- Vomiting
- Diarrhea
- Constipation
- Change in bowel habits
- Abdominal pain
- Black, tarry bowel movements
- Blood in bowels

Genitourinary:

- Burning with urination
- Blood in urine
- Discharge
- Urinary frequency
- Urinary hesitancy
- Waking up at night to urinate
- Incontinence (leaking urine)
- Genital sores

Musculoskeletal:

- Back pain
- Joint pain
- Joint swelling
- Muscle cramps
- Muscle weakness
- Stiffness
- Arthritis

Skin:

- Rash
- Itching
- Dryness
- Suspicious lesions/moles

Neurologic:

- Paralysis
- Weakness
- Numbness
- Seizures
- Fainting (Syncope)
- Tremors or shakes
- Dizziness
- Headache

Psychiatric:

- Memory loss
- Hallucinations
- Mental disturbance
- Suicidal thoughts
- Anxiety
- Depression

Endocrine:

- Cold intolerance
- Heat intolerance
- Excessive thirst
- Excessive hunger
- Excessive urination
- Weight change

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Female Reproductive:

- Irregular menses
- Hot flashes
- Decreased sex drive

Age periods started _____

Last normal menses _____

Number of pregnancies _____

Male Reproductive:

- Change in shaving frequency
- Breast enlargement or tenderness
- Erectile Dysfunction
- Decreased sex drive

Heme/Lymphatic:

- Abnormal bruising
- Bleeding
- Enlarged lymph nodes