Macoupin Family Practice Centers, LLP
New Patient Form

Name (with middle initial) _____ Date _____

SS# _____ DOB _____ Marital Status _____ Occupation _____

Please answer the following questions. Indicate if N/A.

	Yes	No	What/How Much/How Often
Do you use tobacco products?	___	___	_____
Do you use alcoholic beverages?	___	___	_____
Do you use other drugs?	___	___	_____
Do you drink caffeinated beverages?	___	___	_____
Do you drink energy drinks?	___	___	_____
Do you exercise?	___	___	_____
Have you traveled out of the country in the last year?	___	___	Where to? _____
Do you wear glasses or contacts?	___	___	_____
Do you wear a hearing aid?	___	___	
Have you ever had a problem with anesthesia?	___	___	Explain _____

Number of pregnancies: _____ Number of live births: _____

Allergies (drug & other)	**Current Medications (prescription & other)**	**Previous Surgeries (type and date)**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

When did you last have (if ever):

Pap Smear	_____	Colonoscopy	_____
Mammogram	_____	TB Skin Test	_____
Prostate Exam	_____	Tetanus Vaccine	_____
Eye Exam	_____	Flu Vaccine	_____
Hearing Test	_____	Pneumonia Vaccine	_____
		Hepatitis Vaccine	_____

Please check if you or any family member have experienced these problems

	You	Family		You	Family
Heart Disease	_____	_____	Arthritis	_____	_____
High Blood Pressure	_____	_____	Glaucoma	_____	_____
Stroke	_____	_____	Emphysema	_____	_____
Kidney Disease	_____	_____	Tuberculosis (TB)	_____	_____
Exposure to HIV	_____	_____	Cancer	_____	_____
Hepatitis, Jaundice	_____	_____	Seizures	_____	_____
Sickle Cell Trait	_____	_____	Diabetes	_____	_____
Alzheimer's	_____	_____	Asthma	_____	_____

Check all of the following problems you are currently experiencing:

General:
___Weight Loss
___Weight gain
___Night Sweats
___Loss of appetite
___Weakness

Skin and/or breast:
___Rashes
___Hair loss
___Non-healing sore
___Breast discharge
___Breast pain
___Lump(s) in breast

HEENT:
___Pain in eyes
___Poor vision
___Seeing double
___Itching, tearing
___Blurred vision
___Watery eyes
___Poor hearing
___Ringing in ears
___Lump in neck
___Nose congestion
___Nosebleeds
___Earaches
___Bleeding gums
___Persistent sores in mouth

Respiratory:
___Shortness of breath
___Cough
___Coughing blood

Cardiovascular:
___Chest pain
___Rapid heartbeat
___Irregular heartbeat
___Ankle swelling
___Pain in legs

Gastrointestinal:
___Heartburn
___Nausea
___Constipation
___Diarrhea
___Stomach pain
___Gas/belching
___Indigestion
___Blood in stools
___Difficulty swallowing

Genitourinary:
___Blood in urine
___Frequent urination
___Difficulty urinating
___Dribbling
___Sores
___Menstrual cramps
___Irregular menstruation
___Heavy menstruation
___Discharge
___Lumps on testicles

Musculoskeletal:
___Pain in joints
___Muscle weakness
___Back pain
___Joint stiffness
___Joint swelling

Neurological:
___Dizziness
___Headaches
___Fainting
___Memory loss
___Inco-ordination
___Tremors
___Difficulty walking
___Difficulty speaking

Psychiatric:
___Irritability
___Anxiety
___Nervousness
___Difficulty sleeping
___Lonely, depressed
___Suicidal

Endocrine:
___Heat intolerance
___Cold intolerance
___Always hungry
___Excess thirst
___Excess urination

Hematology:
___Bruise easily
___Frequent infections
___Chronic fatigue

Physician's signature: _____ Date: _____