Willis Knighton Health

NEW PATIENT HISTORY and ROS (Please print the following information)

Date _____ Age_____

Patient Name _____ Male___ Female____ Date of Birth _________

Address _____ Marital Status: ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Single

_____ Residence Phone ( )_____

_____ Business Phone ( )_____

FAMILY HISTORY - List Immediate family members who have died (Father, Mother, etc.):

_____

_____

_____

Circle Illnesses immediate family members have had:

Tuberculosis	Heart Disease	Hay Fever	Glaucoma
Diabetes	High Blood Pressure	Asthma	
Cancer	Allergies	Sickle Cell Anemia	

PATIENT HISTORY; Please check if your medical history includes:

Date of last dental exam: _____ **REVIEWER NOTES**

EYE, EAR, NOSE
1. Hay Fever ____
2. Ear Infection ____
3. Hearing Loss ____
4. Eye Problems ____

GASTROINTESTINAL
5. Stomach Pain ____
6. Ulcers ____
7. Change In bowel Habits ____
8. Rectal Bleeding ____
9. Jaundice (Hepatitis) ____

CARDIO-RESPIRATORY
10. Trouble Breathing ____
11. Cough (If chronic) ____
12. Asthma ____
13. High Blood Pressure ____
14. Rheumatic Fever ____
15. Heart Disease ____
16. Activity Limitation ____
17. EKG-Last Date _____
18. Chest X-Ray - Date _____

GENITOURINARY
19. Difficulty starting stream ____
20. Night time urination ____
21. Kidney Disease ____
22. Urinary Infection ____

NEURO-MUSCULAR
23. Weakness ____
24. Numbness/Tingling ____
25. Muscle Pain ____
26. Seizures/Epilepsy ____
27. Paralysis ____
28. Migraine/Headaches ____

SKELETAL
29. Joint Pain or Swelling ____
30. Back Problems ____
31. Arthritis ____

ENDOCRINE
32. Diabetes ____
33. Thyroid Problems ____
34. Recent Weight Gain/Loss (10 pounds) ____

HEMATOLOGIC
35. Sickle Cell Disease ____
36. Anemia ____
37. Bleeding Tendencies ____
38. Thrombophlebitis/blood clots ____

OTHER (Additional space on back)
39. Cancer ____
40. Mental/Emotional Problems ____
41. Venereal Disease History ____
42. Tetanus Immunization
Last Date: _____

FOR WOMEN ONLY
43. Irregularity of Periods_____ 44. Abnormal Flow_____ 45. PID/Pelvic Pain_____ 46. Breast Disease____
47. Last Menstrual Period, Date:_____ 48. Last Pelvic/Pap Smear Date:_____
49. Birth Control? If so, what type:_____ 50. Number of Pregnancies:_____ Number of Births:_____

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Patient Name _____ Date of Birth _________ Patient History. Cont'd.

PLEASE LIST ALL SURGERIES, HOSPITALIZATIONS, AND/OR SERIOUS INJURIES:

_____

_____

_____

PLEASE INCLUDE ALL CURRENT PRESCRIPTIONS, OVER THE COUNTER MEDS, HERBALS, PATCHES, INHALER, EYE DROPS & SUPPLEMENTS:

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

PREFERRED PHARMACY: _____

PLEASE NAME ANY DRUG ALLERGIES/ADVERSE REACTIONS:

_____ _____ _____

_____ _____ _____

_____ _____ _____

CURRENT LIFE STYLE: Name your current occupation _____

	NO	YES
Do you use alcohol more than four times per week?	_____	_____
Do you smoke?	_____	_____
Do you ever use drugs recreationally?	_____	_____
Do you feel safe in your environment?	_____	_____

Indicate any abnormality	YES	NO	Description
A) Eyes	_____	_____	_____
B) Ears, Nose, Throat	_____	_____	_____
C) Skin	_____	_____	_____
D) Nervous System	_____	_____	_____
E) Chest	_____	_____	_____
F) Heart	_____	_____	_____
G) Abdomen	_____	_____	_____
H) Genito-Urinary System	_____	_____	_____
I) Pelvic	_____	_____	_____
J) Extremities	_____	_____	_____
K) Back	_____	_____	_____
L) Pain - Location	_____	_____	Pain Scale 0 1 2 3 4 5 6 7 8 9 10

Completed by: _____
Signature Printed Name Date/Time

Reviewed with patient by: _____
Provider Signature Printed Name Date/Time