Do you have or have you had (past) any of the following conditions?

SYMPTOMS/ ILLNESS	NO	YES, Explain (Dr. overseeing or condition resolved?)	SYMPTOMS/ ILLNESS	NO	YES, Explain (Dr. overseeing or condition resolved?)
CONSTITUTIONAL			**NEUROLOGIC**		
Fever or Chills			Stroke		
Weight Loss			Seizures		
HEMATOLOGIC			TIA		
Hepatitis			Migraines/Headaches		
Blood clots / DVT			Balance Issues		
Anemia / Bleeding Disorders			**GENITOURINARY**		
ENDOCRINE			Kidney Disease		
Thyroid Problems (hypthyroid/ hyperthyroid)			Kidney Stones		
Diabetes			Herpes		
Other			**IMMUNE SYSTEM**		
MUSCULOSKELETAL			HIV/AIDS		
Arthritis			Lupus		
Fibromyalgia			Immunocompromised		
Mobility/ Joint Problems			**SKIN**		
Muscle Injury			Rashes		
Rhabdomyolosis			Eczema		
GASTROINTESTINAL			Psoriasis		
Irritable Bowel Syndrome			Wounds		
Colon Issues			MRSA		
Ulcers			**RESPIRATORY**		
Liver Disease (i.e hepatitis, cirrhosis)			Asthma		
Gastroesophageal Reflux (Heartburn, GERD)			COPD		
CARDIOVASCULAR			Pneumonia		
Deep Vein Thrombosis (DVT), Blood Clots			Sleep Apnea		
High Blood Pressure			**FAMILY MEDICAL HISTORY**		
Heart Attack			Father: Age: _____ History: _____ Deceased: YES or NO Mother: Age: _____ History: _____ Deceased: YES or NO Siblings: Age: _____ Age: _____ Age: _____ Age: _____ Age: _____ History: _____ Deceased: YES or NO Children: Age: _____ Age: _____ Age: _____ Age: _____ Deceased: YES or NO		
High Cholesterol					
Irregular Heart Beat					
Pace Maker					
Aneurysm					

Philip C. Kierney, M.D.
C.J. Lynn Chung, M.D.

New Patient History Form

Name: _____ **Birth Date:** _____/_____/_____ **Date:** _____/_____/_____
Reason for today's visit: _____
Please describe this problem: _____
Prior Surgeries/Hospitalizations: _____
Profession: _____ **Employer:** _____

MEDICATIONS: Please list (or show us your own printed record) **ALL** prescriptions and non-prescription medications, including the dosage and frequency. This includes vitamins, herbs, supplements, home remedies, birth control pills, inhalers, and over the counter pain pills (Advil, Aleve, Tylenol, etc):

_____

_____

Do you take any blood thinning products, such as Vitamin E, Plavix, Coumadin, or Aspirin? YES NO
Do you have any drug allergies? YES NO (If yes, please list below)

Allergy:	Reaction:

IMMUNIZATIONS: Enter year (if known) of any vaccinations you have had.
Tetanus _____ Hepatitis B _____ Flu shot _____ PPD (TB test) _____
Covid19_____

WOMEN'S HEALTH HISTORY:
Are you currently pregnant? YES NO Do you plan to become pregnant? YES NO
Have you had recurrent miscarriages? YES NO

PERSONAL MEDICAL HISTORY:
Previous Injuries? (Including arms or neck): _____
Do you ever loose your balance and need to steady yourself on furniture when moving about? YES NO
Have you fallen in the last 3 months or have a history of falling? YES NO
Do you have sensitive/fragile skin or areas of skin breakdown? YES NO
Do you have an Advance Directive? YES NO
Would you like information on Advance Directive? YES NO

PATIENT SOCIAL/CULTURAL HISTORY:
Martial Status: Single Married Widowed Divorced Separated
Do you live alone? YES NO
Alcohol Use: NEVER RARELY SOCIALLY DAILY How much? _____
Cigarette/Tobacco: YES Packs per/day: _____ QUIT When?_____ NEVER
Drug Use: YES Drugs used: _____ QUIT When? _____ NEVER
Do you have any cultural or spiritual practices that you would like to be known or have incorporated in your care?
_____