A New U Wellness Clinic

Patient: _____ Date: _____/_____/_____

Reason for today's visit: _____

Are you allergic to any medications? ☐ **YES** ☐ **NO** If yes, list below:

1. _____ 2. _____

Have you ever had dental anesthesia (Novocain)? ☐ **YES** ☐ **NO** Any bad reaction? ☐ **YES** ☐ **NO**

List all medications you are currently taking (including prescriptions, over-the-counter meds, vitamins, and herbals):

1. _____ 2. _____ 3. _____

4. _____ 5. _____ 6. _____

Do you have now, or have you ever had diseases or conditions of: (Please check YES or NO)

Lungs:	**YES**	**NO**	**Other Systemic:**	**YES**	**NO**
Bronchitis	☐	☐	Diabetes	☐	☐
Emphysema	☐	☐	Excessive thirst/hunger	☐	☐
Asthma	☐	☐	Thyroid	☐	☐
Chronic Cough	☐	☐	Kidney	☐	☐
Morning Cough	☐	☐	Bladder	☐	☐
Shortness of Breath	☐	☐	Frequency/Burning	☐	☐
Wheezing	☐	☐	Gastrointestinal	☐	☐
			Stomach absorptive disorder	☐	☐
Cardiovascular:			Nausea, vomiting, diarrhea		
High Blood Pressure	☐	☐	when taking antibiotics	☐	☐
Chest Pain	☐	☐	Yeast infection when taking antibiotics	☐	☐
Heart Attack	☐	☐	Arthritis/Joint Deformity	☐	☐
Heart Murmur	☐	☐	Arthralgia	☐	☐
Irregular Heartbeat	☐	☐	Limited Motion	☐	☐
Phlebitis	☐	☐	**Artificial Joint**	☐	☐
Inflammation of vein	☐	☐	Convulsions, Epilepsy, or Seizures	☐	☐
Blood Clots	☐	☐	Fainting	☐	☐
Pacemaker	☐	☐			

List any other diseases or conditions: _____

List surgical procedures you have had in the last 6 months: _____

Skin:

Have you ever had skin cancer: ☐ YES ☐ NO

Has anyone in your family had skin cancer? ☐ YES ☐ NO

Do you have a history of specific skin diseases? ☐ YES ☐ NO If yes, _____

Do you have problems with healing? ☐ YES ☐ NO

Do you develop keloids (scars) after surgery? ☐ YES ☐ NO

Do you bleed easily? ☐ YES ☐ NO

Do you develop skin rashes in reaction to: ☐ Medications ☐ Food ☐ Environment? _____

Social History:

Do you drink alcohol? ☐ YES ☐ NO If yes, _____ drinks per day

Do you use IV drugs? ☐ YES ☐ NO If yes, what? _____ How often? _____

Do you smoke? ☐ YES ☐ NO If yes, how much? _____

Have you had or ever been exposed to HIV (AIDS)? ☐ YES ☐ NO

(Women) Are you pregnant? ☐ YES ☐ NO Due Date: _____/_____/_____

What is your occupation? _____ Hobbies? _____

Completed by: ☐ Patient/Legal Guardian

☐ Medical Assistant _____
Initials

_____ ____/____/____
Patient/Legal Guardian Signature Date

_____ ____/____/____
Reviewed by Date