New Patient

Print Your Name | Your Signature | Today's Date

Town Family Doctor
Vedad Seremet MD

History of Present Illness(es):

Main problem/ Reason for this appointment (if possible rank in terms of importance to you)	Additional problems or concerns you would like addressed (We may not be able to address every problem during the course of one visit)
1.	1.
2.	2.
3.	3.

Please list your current Medication, Herbs, Vitamins, Supplements including doses and how often taken. NONE	Are you allergic or intolerant to any medication, latex, food etc? Please list and describe your reaction. NO KNOWN ALLERIGIES
1.	1.
2.	2.
3.	3.
4.	4.
5.	5.

Review of System(s):

Please circle any symptoms that currently apply to you

Constitutional
Fever, Sweats, Chills
Body aches
Fatigue
Weight loss/gain

Eyes
Redness, discharge
Watery, Itchy eyes
Pain, Foreign body
Photophobia
Poor, Blurred vision

Ear, Nose, Throat
Ringing ears
Ear pain, Drainage
Hearing loss

Nosebleeds
Runny nose, Sneezing
Sinus pressure, Pain

Sore throat
Swollen glands
Trouble with taste
Post nasal drip
Snoring
Hoarseness

Cardiovascular
Angina
Chest pain
Rapid heart rate
Skipping heart beat
Lightheadedness
Fainting
Swollen feet
Leg pain with walking
Cold hands/feet

Respiratory
Dry cough
Productive cough
Wheezing
Chest tightness
Shortness of breath
Frequent infection

Gastrointestinal
Problem swallowing
Heartburn, Acid reflux
Nausea, Vomiting
Diarrhea
Constipation
Dark stool
Bloating
Stomach pain

Kidneys & Urinary
Painful, frequent
Heavy odor
Dark urine
Blood in urine
Loss of urine control

Musculoskeletal
Muscle pain
Joint pain
Joint swelling
Morning stiffness
Neck/Back pain

Skin
Acne
Dry, Oily skin
Hives, Itchy Skin
Rash, Eczema
Psoriasis
Fungal infection
Frequent boils
Blisters, Lumps
Skin pigmentation
Moles new
Nail problems

Neurological
Headache
Weakness
Change in speech
Numbness
Fainting
Muscle weakness
Dizziness
Tremors
Restless legs

Psychiatry
Anxiety and
Depression
Persistent sadness
Unable to enjoy life
Sleep disturbance
Easy crying
Irritable and angry
Panic attack
Confusion

Endocrine
Excessive urination
Excessive thirst
Excessive hunger
Weakness
Hair change
Heat intolerance

Hematology
Bruising
Bleeding
Slow healing
Lymph nodes

Female only
Breast lumps, pain
Breast discharge
Irregular periods
Hot flashes
Vaginal dryness
Vaginal discharge
Vaginal warts
Excessive hair growth

Last period:

Male & Female
Painful intercourse
No sexual interest
Infertility
Sores on genitals

Male only
Hernia
Urine flow problems
Testicular pain
Erectile dysfunction
Prostate disease
Sterility
Bloody ejaculation

Past Medical History

List all medical conditions you have had in the past	(Year) Surgeries	(Year) Hospitalizations
1.	1.	1.
2.	2.	2.
3.	3.	3.
4.	4.	4.
5.	5.	5.

Family History

Write down medical conditions below that apply to your biological family and assign it to a family member

Allergies	Heart Attack	Ulcer	Pneumonia	Anemia	Bipolar	Migraine	Stroke	Cancer
Asthma	Blood Pressure	Liver Disease	Tuberculosis	Bleeding	Anxiety	Suicide	Birth Defects	Prostate
COPD	Heart Disease	Kidney	AIDS	Sickle Cell	Depression	Alzheimer's	Thyroid	Breast
Emphysema	Obesity	Diabetes	Arthritis	Glaucoma	IBS	Epilepsy	Eczema	Colon
Autoimmune		Hiatal Hernia	Joint Problem	Gout	Alcoholism	Mental	Psoriasis	Melanoma

What is the status of your?	Living		Age	Medical Conditions
Mother	Yes	No		
Father	Yes	No		
Maternal G-ma	Yes	No		
Maternal G-pa	Yes	No		
Paternal G-ma	Yes	No		
Paternal G-pa	Yes	No		
Sister	Yes	No		
Sister	Yes	No		
Sister	Yes	No		
Brother	Yes	No		
Brother	Yes	No		
Brother	Yes	No		
Maternal Aunts & Uncles	Yes	No		
Paternal Aunts & Uncles	Yes	No		
Other	Yes	No		

Social History & Lifestyle

(circle and answer those that apply)

Born and raised where?			
Current job?			
Previous jobs?			
Education level completed?			High School, College, Professional School, Other:
Married?	Yes	No	
Children (list sex and age)?	Yes	No	
Who lives with you?			
Currently smoke cigarettes?	Yes	No	If yes, how many years? Plan to quit smoking? No Yes When?
Ever smoke?	Yes	No	If yes, when did you quit?
Drink alcohol?	Yes	No	If yes, which type & number of drinks per week or day?
Drink caffeinated beverages?	Yes	No	If yes, how many cups per day?
Enjoy recreational drugs?	Yes	No	If yes, which and how often?
Exercise 3x a week at least 30 min?	Yes	No	If no, why?
Is your diet healthy enough?	Yes	No	Not sure Need Help
Manage stress well?	Yes	No	Not Sure Need help
Allow time to relax?	Yes	No	If no, why?
Enjoy your job?	Yes	No	If no, why?
Satisfied with your sex life?	Yes	No	If no, why?
Satisfied with your social life?	Yes	No	If no, why?
Memories of your childhood?			Mostly happy, Mostly painful, Normal, Don't recall,
Major stressors in last 6 months?			Money, Job, School, Marriage, Children, Health, Other:
Do You Find Your Life?			Generally Unsatisfactory, Too Demanding, Boring, Satisfactory,

Health Screening History

Circle Most recent Test & Date

Mammogram	Cholesterol	Flu Shot
Pap Smear	Colonoscopy	Tetanus
Breast Exam	Prostate Specific Antigen (PSA)	Hepatitis B Vaccine
	Prostate Exam	Pneumonia Vaccine