NEWTOWN INTERNAL MEDICINE
A Functional and Holistic Approach

PATIENT HISTORY FORM – page 1 of 2

Today's Date: ____/____/____ **Date of Birth:** ____/____/____

Last Name: _____ **First Name:** _____

Chief Complaint:
What is the main reason for your visit today? (Describe your problems in detail)

_____

_____

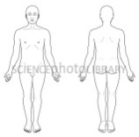
History of Present Illness

Please answer the following questions

Location of the problem
Abdomen, Back, Leg, Head, Other

_____

_____



Front Back

On a Scale of 1-10, with 10 being the most severe, circle the number that describes the problem?
1 / 2 / 3 / 4 / 5 / 6 / 7 / 8 / 9 / 10

When did you first notice the problem?
2 days ago, 2 weeks ago, 1 month ago, other _____

Does anything help or make the problem worse?
Moving around, standing up, and lying on my side, other _____

How long does the problem last?
30 minutes, 1 hour, it is always there, other
_____

Is anything else occurring at the same time?
No Yes - please explain:
Nausea, Rash, Headaches, other
_____

Is the problem constant or variable?
Dull then sharp, Very sharp then leaves, Always there, other
_____

Does the problem interfere with your normal functions?
No Yes - please explain:
_____

Past Medical History

List all your illnesses since you were born
(Example: Diabetes, Heart Disease, Lung Disease, Cancer, etc)

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

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PATIENT HISTORY FORM – page 2 of 2

Past Surgical History

List all procedures that required anesthesia with dates
(Example: surgeries, endoscopy, colonoscopy)

Surgery/Procedure	Date	Surgery/Procedure	Date
_____	____/____/____	_____	____/____/____
_____	____/____/____	_____	____/____/____
_____	____/____/____	_____	____/____/____
_____	____/____/____	_____	____/____/____

List of Medications / Supplements with Doses

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

List any allergies

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

Do you exercise? No Yes
If Yes, how often? _____ What kind of exercise do you do? _____

Have you ever smoked? No Yes
If Yes, how much per day? _____ For how long? _____ If quit, when did you quit? _____

If you continue to smoke, how much per day? _____ How long have you been smoking? _____

Do you drink alcohol? No Yes
If Yes, how much? _____ How often? _____

Do you follow any diet? No Yes
if Yes, what kind?
_____

What kind of work do you do or used to do?

_____

Any occupational or toxic exposure in the past or currently?

_____

What do you do for relaxation and any hobbies?

_____

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