NEW PATIENT HISTORY

Patient: _____ Date: _____

Reason for today's visit: _____

Are you allergic to any medications? ☐ YES ☐ NO If yes, please list: _____

Have you ever had a reaction to dental anesthesia (Novocaine) or local anesthesia (Lidocaine)? ☐ YES ☐ NO

Explain, if yes _____

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

_____

_____

Primary Physician _____

General Health: _____ Poor _____ Fair _____ Good _____ Excellent

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

Lungs:	YES	NO
Bronchitis	☐	☐
Emphysema	☐	☐
Asthma	☐	☐
Chronic Cough	☐	☐
Tuberculosis	☐	☐
Shortness of Breath	☐	☐

Cardiovascular:	YES	NO
High Blood Pressure	☐	☐
Heart Attack	☐	☐
Heart Murmur	☐	☐
Irregular Heartbeat	☐	☐
Pacemaker	☐	☐
Varicose Veins	☐	☐
Blood Clots	☐	☐
Bleeding Disorders	☐	☐
Prolonged Bleeding	☐	☐
Anemia	☐	☐
Stroke	☐	☐

Skin:	YES	NO
History of Skin cancer	☐	☐
if yes, type _____		
Family history of skin cancer	☐	☐
if yes, type _____		
History of specific skin diseases	☐	☐
Problems with healing	☐	☐
Excessive scarring/Keloids	☐	☐
Easy Bleeding	☐	☐
Skin Rashes	☐	☐
Reaction to Medications	☐	☐
Reaction to Food	☐	☐
Reaction to Environment	☐	☐
Sensitivity to Sunlight	☐	☐

Other Systemic:	YES	NO
Diabetes	☐	☐
Lupus	☐	☐
Thyroid Disease	☐	☐
Kidney Disease	☐	☐
Bladder Infections	☐	☐
Connective Tissue	☐	☐
Stomach Disorder	☐	☐
Stomach Ulcers	☐	☐
Nausea, Vomiting, diarrhea when taking antibiotics	☐	☐
Yeast infection when taking antibiotics	☐	☐
Athritis/Joint Deformity	☐	☐
Convulsions/Epilepsy	☐	☐
Seizures	☐	☐
Fainting	☐	☐
Anxiety/Depression	☐	☐
Mental Disorder	☐	☐
Glasses/Contacts	☐	☐
Liver Disease	☐	☐
Cancer	☐	☐
Type _____		
Polycystic Ovarian Disease	☐	☐
Hirsutism/Hypertrichosis	☐	☐
Cushing's disease	☐	☐

Social History:	YES	NO
Do you smoke?	☐	☐
If yes, for how many years _____		
_____ packs per day		
Do you drink alcohol?	☐	☐
If yes, _____ per day		

Infectious Disease:	YES	NO
HIV/AIDS	☐	☐
Hepatitis: A B or C *(please circle)*		
Syphilis/other STD's	☐	☐
Herpes Simplex	☐	☐
HPV	☐	☐
Flat Warts	☐	☐
Molluscum	☐	☐

Females:	YES	NO
Are you pregnant?	☐	☐
Could you be pregnant?	☐	☐

Date of last menstrual cycle: _____

Type of birth control

_____

Previous pregnancies

_____

_____

_____

Past Medical History:

_____

_____

_____

_____

_____

Past Surgical History:

_____

_____

_____

_____

_____

I hereby declare that I have honestly and completely answered the above questions to the best of my knowledge. I understand that it is my obligation and responsibility to notify Dr. Richard N. Sherman of any changes in my medical condition or medications during the course of my medical treatments or at follow-up visits.

Patient Signature	Date Signed	Reviewed By	Date
_____	_____	_____	_____

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