

Pharmacy Address:  
 \_\_\_\_\_  
 \_\_\_\_\_



Date: \_\_\_\_\_

Pharmacy Phone: \_\_\_\_\_

**New Patient Health History**

*Welcome to Dr. Herscovici's office. In order to effectively treat you, it is necessary that we obtain a complete medical history. Please fill out all areas of this form leaving no blanks. If an item does not apply to you, write "NA" in that section. If you need help, ask one of the staff.*

Age: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Referring Physician: \_\_\_\_\_

Name: \_\_\_\_\_ Occupation: \_\_\_\_\_

Problem/Injury: (Right/Left) \_\_\_\_\_

Date of Onset/Injury: \_\_\_\_\_ Work Related? ( YES / NO ) \_\_\_\_\_

**Past Medical History & Review of Systems (Circle all that apply)**

- |                     |                      |                           |                                  |
|---------------------|----------------------|---------------------------|----------------------------------|
| Heart Disease       | Rashes               | Indigestion/Ulcers        | Difficulty Sleeping              |
| High Blood Pressure | Headaches            | Psychiatric Problems      | Hematologic/Lymphatic            |
| Asthma              | Epilepsy/Convulsions | Arthritis                 | Diabetes                         |
| Coughing            | Eyes                 | Kidney/Bladder Infections | Thyroid                          |
| Pneumonia           | Ears/Hearing         | Excessive Wt loss/Gain    | Fever/Chills/Unusual Weight Loss |

Other (List): \_\_\_\_\_

**Medications: (Continue on back if necessary)**

Medication	Dosage (mg or %)	How Often	For What Purpose

Allergies: \_\_\_\_\_ Health Habits:  
 \_\_\_\_\_ Tobacco ( Y / N ): Amount \_\_\_\_\_  
 \_\_\_\_\_ Alcohol ( Y / N ) : Amount \_\_\_\_\_

Family History: \_\_\_\_\_ Children: ( Y / N ) Ages \_\_\_\_\_  
 Diabetes ( Y / N ) \_\_\_\_\_ Other: \_\_\_\_\_  
 Heart Disease ( Y / N ) \_\_\_\_\_  
 Cancer ( Y / N ) \_\_\_\_\_

**Past Surgical History: (Continue on Back if necessary)**

Date	Procedure	Hospital	Outcome

Sports: \_\_\_\_\_

Hobbies: \_\_\_\_\_

(Right Handed / Left Handed) Circle one

*Please complete this history of your primary complaint. Be specific as possible.  
The Physician will also obtain a history during your visit.*

**Primary Complaint:** (A brief history of the location, duration and cause of the problem)

**Date of Onset/Duration of Symptoms:** \_\_\_\_\_

**Things which make the symptoms worse:** \_\_\_\_\_

**Things which make the symptoms better:** \_\_\_\_\_

**Pain at worst (0-10)** \_\_\_\_\_ **Pain at best (0-10)** \_\_\_\_\_

(Scale: 0 = No Pain, 10 = Pain severe enough to amputate the arm or leg)

**Treatment to Date for this specific problem:**

Medications: ( Yes / No )

List: \_\_\_\_\_

Physical therapy: ( Yes / No )

Details: \_\_\_\_\_

Bracing or Orthotics: ( Yes / No )

Details: \_\_\_\_\_

Surgery/ ( Yes / No )

Procedure	Date	Surgeon	Hospital	Result

\_\_\_\_\_  
**Patient Signature**

\_\_\_\_\_  
**Physician Reviewer**