

**KEITH H. FIMAN, M.D., P.A.**

**NEW PATIENT HISTORY**

NOTE: The information requested is necessary for a complete evaluation of your medical problem. Please answer as completely and accurately as possible. All answers are confidential, and information you provide will be released only with your written permission or in an emergency.

NAME: \_\_\_\_\_

AGE: \_\_\_\_\_

**PRIMARY CARE PHYSICIAN:** \_\_\_\_\_

**REFERRING PHYSICIAN (IF DIFFERENT):** \_\_\_\_\_

What is the reason for today's visit? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**ALLERGIES**

Do you have any medication allergies? \_\_\_\_\_  
(If yes, please list your allergies) \_\_\_\_\_

Are you allergic to Latex?                    \_\_\_ Yes    \_\_\_ No

Are you allergic to X-ray dye (or iodine)?                    \_\_\_ Yes    \_\_\_ No

**MEDICATIONS**

Please list your prescription medications, including dose and how often you take each medicine:

- |          |           |
|----------|-----------|
| 1. _____ | 9. _____  |
| 2. _____ | 10. _____ |
| 3. _____ | 11. _____ |
| 4. _____ | 12. _____ |
| 5. _____ | 13. _____ |
| 6. _____ | 14. _____ |
| 7. _____ | 15. _____ |
| 8. _____ | 16. _____ |

Please list nonprescription medications and supplements (including baby aspirin, if applicable):

- |          |           |
|----------|-----------|
| 1. _____ | 6. _____  |
| 2. _____ | 7. _____  |
| 3. _____ | 8. _____  |
| 4. _____ | 9. _____  |
| 5. _____ | 10. _____ |

**MEDICAL/SURGICAL HISTORY**

(Please check all that apply)

**For Women:** Are you post menopausal?  Yes  No

If not, when was your last menstrual period? \_\_\_\_\_

Have you had a colonoscopy?  Yes

(When? \_\_\_\_\_ )  No

If yes, were polyps removed?  Yes

No  Not applicable

Appendectomy

AIDS/HIV infection

Back Surgery

Alcoholism

Neck Surgery

Arthritis

Brain Surgery

Asthma

Colon Surgery

Cancer

Gall Bladder Surgery

What type? \_\_\_\_\_ )

Ulcer Surgery

Crohn's Disease

Weight Reduction Surgery

Ulcerative Colitis

Cesarean Section (# \_\_\_\_\_ )

Depression

Tubal Ligation

Diabetes

Hysterectomy

(  Type I  Type II )

Breast Surgery

Diverticulitis

Prostate Surgery

Drug use/addiction

Heart Bypass Surgery

Emphysema/COPD

Heart Valve Surgery

Epilepsy/seizures

Tonsillectomy

Gallstones

Orthopedic Surgery

GERD (Esophageal reflux)

Thyroid Surgery

Glaucoma

Other major surgery

Heart Disease

(What type? \_\_\_\_\_ )

(What type? \_\_\_\_\_ )

Anemia

High Blood Pressure

Prior Blood Transfusion

Hepatitis(  B  C  Other )

Problems with Anesthesia

Kidney Disease

Kidney Stones

Stroke/TIA

Thyroid Disease

Ulcers

**FAMILY HISTORY**

Do you have any close relatives with colon cancer?  Yes (Who? \_\_\_\_\_ )  No  
with colon polyps?  Yes (Who? \_\_\_\_\_ )  No

Please list other serious medical problems of close relatives:

\_\_\_\_\_  
\_\_\_\_\_

**SOCIAL HISTORY**

Marital Status (Please circle) Single Married Divorced Separated Widowed

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

Do you smoke cigarettes?  Yes  No (If yes, how much per day? \_\_\_\_\_ )

Do you use smokeless tobacco?  Yes  No

Do you drink alcohol?  Yes  No (If yes, how much per day/week? \_\_\_\_\_ )

**OTHER SYMPTOMS**

Please check the symptoms below if they occur **frequently**, if they have **changed significantly** in the last 30 days, or if you are concerned about them.

**GENERAL**

Fever \_\_\_\_\_  
 Chills \_\_\_\_\_  
 Weight Loss \_\_\_\_\_  
 Weight Gain \_\_\_\_\_  
 Excessive fatigue \_\_\_\_\_  
 Weakness \_\_\_\_\_  
 Insomnia \_\_\_\_\_  
 Loss of Appetite \_\_\_\_\_

**EYES**

Blurred vision \_\_\_\_\_  
 Double vision \_\_\_\_\_  
 Eye pain \_\_\_\_\_  
 Blindness \_\_\_\_\_

**ENT**

Hearing loss \_\_\_\_\_  
 Earache \_\_\_\_\_  
 Ringing in ears \_\_\_\_\_  
 Nosebleeds \_\_\_\_\_  
 Sore throat \_\_\_\_\_  
 Hoarseness \_\_\_\_\_  
 Voice changes \_\_\_\_\_  
 Hay fever \_\_\_\_\_  
 Sinus problems \_\_\_\_\_  
 Allergies \_\_\_\_\_

**ORAL/DENTAL**

Toothache \_\_\_\_\_  
 Sores in mouth \_\_\_\_\_  
 Bleeding gums \_\_\_\_\_  
 Tongue pain \_\_\_\_\_

**HEART**

Chest pain \_\_\_\_\_  
 Short of breath \_\_\_\_\_  
 Palpitations \_\_\_\_\_  
 Fainting spells \_\_\_\_\_

Do you need antibiotics  
 for dental work? Y / N

**VASCULAR**

Calf pain when \_\_\_\_\_  
 walking \_\_\_\_\_  
 Swollen feet \_\_\_\_\_  
 Blood clots \_\_\_\_\_

**RESPIRATORY**

Cough \_\_\_\_\_  
 Coughing up blood \_\_\_\_\_  
 Sleep apnea \_\_\_\_\_  
 Short of breath \_\_\_\_\_  
 Wheezing \_\_\_\_\_

**URINARY**

Painful urination \_\_\_\_\_  
 Difficult Urination \_\_\_\_\_  
 Frequent Urination \_\_\_\_\_  
 Waking to Urinate \_\_\_\_\_  
 Blood in Urine \_\_\_\_\_  
 Dark Urine \_\_\_\_\_  
 Incontinence of \_\_\_\_\_  
 Urine \_\_\_\_\_  
 Impotence (E.D.) \_\_\_\_\_

**DIGESTIVE**

Severe heartburn \_\_\_\_\_  
 Difficult/painful \_\_\_\_\_  
 swallowing \_\_\_\_\_  
 Indigestion \_\_\_\_\_  
 Nausea \_\_\_\_\_  
 Vomiting \_\_\_\_\_  
 Vomiting blood \_\_\_\_\_  
 Abdominal pain \_\_\_\_\_  
 Rectal bleeding \_\_\_\_\_  
 Black stools \_\_\_\_\_  
 Diarrhea \_\_\_\_\_  
 Constipation \_\_\_\_\_  
 Change in bowel \_\_\_\_\_  
 habits \_\_\_\_\_  
 Bloating/gas \_\_\_\_\_  
 Incontinence of \_\_\_\_\_  
 stool \_\_\_\_\_  
 Yellow jaundice \_\_\_\_\_

**MUSCLE/JOINT**

Muscle aches \_\_\_\_\_  
 Back pain \_\_\_\_\_  
 Arthritis \_\_\_\_\_  
 Swollen joints \_\_\_\_\_  
 Weak muscles \_\_\_\_\_

**NEUROLOGICAL**

Headaches \_\_\_\_\_  
 Muscle weakness \_\_\_\_\_  
 Loss of sensation \_\_\_\_\_  
 Seizures \_\_\_\_\_  
 Dizziness (spinning) \_\_\_\_\_  
 Slurred speech \_\_\_\_\_  
 Falling episodes \_\_\_\_\_

**ENDOCRINE**

Intolerant of heat/cold \_\_\_\_\_  
 Excessive thirst \_\_\_\_\_  
 Excessive hunger \_\_\_\_\_  
 Menstrual problems \_\_\_\_\_  
 Swollen glands \_\_\_\_\_

**SKIN**

Rash \_\_\_\_\_  
 Skin lesions \_\_\_\_\_  
 Excessive hair loss \_\_\_\_\_  
 Enlarging moles \_\_\_\_\_  
 Itching \_\_\_\_\_

**PSYCHIATRIC**

Depression \_\_\_\_\_  
 Anxiety \_\_\_\_\_  
 Panic attacks \_\_\_\_\_  
 Memory loss \_\_\_\_\_  
 Confusion \_\_\_\_\_

**BLOOD DISORDERS**

Easy bruising \_\_\_\_\_  
 Anemia \_\_\_\_\_  
 Frequent infections \_\_\_\_\_