

## New Patient Comprehensive History Form

---

**Fox and Brantley Internal Medicine**  
**916 East High St. Suite 1**  
**Charlottesville, VA. 22902**

**Confidential Record: Information contained here will not be released except when you have authorized us to do so.**

### Demographic Information

Last Name \_\_\_\_\_ First \_\_\_\_\_ Middle \_\_\_\_\_

DOB \_\_\_\_/\_\_\_\_/\_\_\_\_ Email \_\_\_\_\_

Street address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip code \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

**Emergency Contact:** Name \_\_\_\_\_

Relationship to you \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

May we discuss routine lab results with someone else in your home if you are not there?

Y/N If so, whom? \_\_\_\_\_

Prior physician or referring physician \_\_\_\_\_

Date of last office visit there \_\_\_\_\_

How did you hear about our practice? \_\_\_\_\_

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

Please list the issues you want to discuss with your doctor.

\_\_\_\_\_

\_\_\_\_\_

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

**Personal Information**

Birth place \_\_\_\_\_ Education level \_\_\_\_\_

Occupation \_\_\_\_\_ Marital or relationship status \_\_\_\_\_

Describe religious or spiritual support \_\_\_\_\_

Do you have an advanced directive or living will? \_\_\_\_\_

Do you have a Health Care Power of Attorney? Y/N If so, who have you designated?

Name \_\_\_\_\_

Contact information \_\_\_\_\_

**Past Medical, Surgical, and Psychological History**

Please describe or list medical illnesses that you have or for which you have been treated:

List any operations you have had:

Describe any psychological (mental health) conditions for which you have received treatment or assistance (e.g.: medications, counseling, hospitalizations):

List date and reason for all prior hospitalizations:

Describe serious injuries or accidents that you have had:



**For Men:**

Have you discussed prostate cancer screening with a doctor? **Y/ N**

Have you had a prostate blood test (PSA) in the past? **Y/ N**

If you have ever had abnormal result, please describe: \_\_\_\_\_

\_\_\_\_\_

**For Men and Women:**

Have you had a colonoscopy for colon cancer screening? **Y/ N** If yes, date: \_\_\_\_\_

Results \_\_\_\_\_

What is your cholesterol level? Total \_\_\_\_\_ LDL \_\_\_\_\_ HDL \_\_\_\_\_ unknown \_\_\_\_\_

Have you had x-ray or radiation treatments, other than for treating cancer? **Y/ N**

Have you ever had high blood pressure? **Y/ N** If yes, describe: \_\_\_\_\_

**Immunizations:  
Please list the date(s) of your immunizations**

Tetanus:	Pneumovax:	Zostavax:
Hepatitis A:	Hepatitis B:	Other:

**Family Health History:**

Because some names may be used for either men or women, please indicate the sex of each brother, sister, son, or daughter

Family Member	If Living			If Deceased	
	Sex	Age	Health	Age of death	Cause of death
Father	M/F				
Mother	M/F				
Brothers/Sisters	M/F				
	M/F				
	M/F				
Husband/Wife					
Sons/Daughters	M/F				
	M/F				
	M/F				

**Please list any relative (parent or sibling) who has or had the following illnesses:**

**Cancer:** Breast \_\_\_\_\_ Prostate \_\_\_\_\_ Other \_\_\_\_\_  
 Colon \_\_\_\_\_ age(s) \_\_\_\_\_ Colon Polyp \_\_\_\_\_ Type \_\_\_\_\_  
(if known)

**Vascular:** High Blood Pressure \_\_\_\_\_ High Cholesterol \_\_\_\_\_  
 Stroke \_\_\_\_\_ Other \_\_\_\_\_

**Early Heart Attack:** Any heart attacks or bypass/stent surgery younger than age 65?

Y / N Who? \_\_\_\_\_

**Mental Health:**

Depression \_\_\_\_\_ Alcoholism \_\_\_\_\_

Drug addictions \_\_\_\_\_ Suicide \_\_\_\_\_ Other \_\_\_\_\_

**Hormonal:** Diabetes \_\_\_\_\_ Thyroid \_\_\_\_\_

Osteoporosis \_\_\_\_\_ Other \_\_\_\_\_

**Other:** TB \_\_\_\_\_ Bleeding tendency \_\_\_\_\_

**Personal Health Habits:**

Do you wear seat belts regularly? **Y / N**

Do you exercise regularly (three times a week) **Y / N** Describe \_\_\_\_\_

---

Do you follow a particular nutritional plan? **Y / N**

Low fat \_\_\_ Low salt \_\_\_ High fiber \_\_\_ Vegetarian \_\_\_ Diabetic diet \_\_\_ Other \_\_\_

How stressful is your life? (circle the number that indicates your stress level)

1      2      3      4      5      6      7      8      9      10  
(not stressful) \_\_\_\_\_ (very stressful)

List the stressors: \_\_\_\_\_

---

Do you cope with stress? **Y / N** How? \_\_\_\_\_

---

Do you currently smoke regularly? **Y/ N**

Cigarettes \_\_\_\_\_ Pipe \_\_\_\_\_ Cigars \_\_\_\_\_ How many packs daily? \_\_\_\_\_

How many years have you smoked tobacco? \_\_\_\_\_

If you quit tobacco, what year did you quit? \_\_\_\_\_

For how many years did you smoke? \_\_\_\_\_ How many packs daily? \_\_\_\_\_

Do you chew tobacco? **Y/ N** How much? \_\_\_\_\_

Do you drink sodas regularly? **Y / N** If yes, how many daily? \_\_\_\_\_

Do you drink alcohol **Y / N** If yes please describe what you drink and how much? \_\_\_\_\_

---

Do you ever feel like you need to cut down on your alcohol? **Y / N**

Do you ever feel angry or upset when other people talk to you about drinking? **Y / N**

Do you ever drink alcohol in the morning? **Y / N**

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Do you feel guilty about your drinking? Y / N

Do you feel sad often? Y / N

Have you noticed that you have lost interest in things you enjoyed in the past? Y / N

Please describe \_\_\_\_\_

**Review of Systems:**

Please circle the symptoms that you have regularly or that have been present in the last month:

<b>GENERAL</b>	<b>HEENT</b>	<b>ENDOCRINE</b>	<b>CARDIOPULMONARY</b>
Headaches Skin Rash Skin Sores Fatigue Fever Loss of appetite	Vision Decreased hearing Ringing in ears Dizziness Problems with teeth Sinus problems Hoarseness	Thyroid problems High blood sugar Increased thirst Increased urination	Chest pain Shortness of breath Palpitations Fainting spells Leg swelling Wheezing Cough
<b>GASTROINTESTINAL</b>	<b>URINARY</b>	<b>MUSCULOSKELETAL</b>	<b>NEUROLOGICAL</b>
Loss of appetite Abdominal pain Nausea or vomiting Constipation Diarrhea Hemorrhoids Blood in stools Problems swallowing	Painful urination Blood in urine Kidney stones Problems urinating Leakage of urine Frequent urination Urgent urination Sexual dysfunction	Arthritis Pain in joints Back pain	Seizures Tremors or shakes Numbness in hands Numbness in feet Weakness Stroke Memory problems

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_