DNA CENTER

New Patient Information

Name_____Email: _____

Address _____

City_____State Zip

Home Phone_____Work _____

Cell Phone_____Social Security Number _____

Date of birth Gender (Male/Female) Age _____

Please Circle: Hispanic/Latin or Non Hispanic/Latin

Please Circle: Asian, Native American, Hispanic, Black, White, Other

Primary Language: _____

Emergency Contact Information

Name_____Relationship _____

Address _____

Phone _____

Who Referred You _____

Primary Care Physician_____

What Lab do you use: _____

Pharmacy_____Located at: _____

Do you have an Attorney: _____

If you have not done so, please provide a copy of your driver's license and insurance

NAME: _____

Chief Complaints: _____

When did this start? _____

What have you done for treatment of this condition? _____

Who or Where have you gone to for treatment? _____

Is there a family history of this?_____**Relation:** _____

Did this problem result from an injury at work?_____**Date** _____

Did this problem result from an accident or fall?_____**Date:**_____
Where:_____
What happened: _____

Work Status: Have you continued to work since this condition started? _____
What type of work do you do? _____
Do you need any out of work documentation for your job? _____

CURRENT MEDICATIONS/DOSAGES:

ALLERGIES (Agents, Specify Reaction: _____

_____ **Allergic to Penicillin?** _____

HABITS (Drugs, Alcohol, Tobacco): _____

How Much_____**How Often** _____

Tobacco Usage: How Long Years_____**How much per day**_____
Have you tried Quitting? _____

PAST MEDICAL HISTORY

TRAUMA (Broken Bones, Head Injury, etc.): Describe:_____

HOSPITALIZATIONS AND OPERATIONS:

Year	Hospital	Diagnosis

FAMILY HISTORY (Circle any that apply):

Diabetes Mellitus, Tuberculosis, Cancer, Stroke, Hypertension, Renal Disease, Gout, Arthritis, Bleeding Disorders, Heart Disease, Migraines

MOTHER: Age_____ Well/Suffers from_____ Deceased from _____

FATHER: Age_____ Well/Suffers from_____ Deceased from _____

SIBLING: Age _____ Well/Suffers from _____ Deceased from _____

SIBLING: Age _____ Well/Suffers from _____ Deceased from _____

SIBLING: Age _____ Well/Suffers from _____ Deceased from _____

CHILD: Age _____ Well/Suffers from _____ Deceased from _____

CHILD: Age _____ Well/Suffers from _____ Deceased from _____

Current Status Check:

GENERAL (Circle Positive Responses): Change in weight or appetite, Problems Sleeping, Night sweats

HEMATIC (Blood): Anemia, Excessive bruising

CENTRAL NERVOUS SYSTEM: Headaches, Seizures, Dizziness, Tremors, Double Vision, Paralysis, Muscle Weakness

EYES: Vision_____ Glasses/Contact Lenses, Glaucoma, Cataracts
Date of Last Eye Exam: _____

EARS: Deafness, Infections, Ringing in the Ears

NOSE AND THROAT: Sinusitis, Hoarseness, Frequent sore throats

BREASTS: Masses, Discharge, Pain

RESPIRATORY: Tuberculosis or contact with Tuberculosis, Cough, Change in cough, Wheezing

CARDIOVASCULAR: Chest Pain, Heart Attack/Disease, Hypertension, Murmur, Palpitations, Thrombophlebitis, Loss of Consciousness

GASTROINTESTINAL: Nausea, Vomiting, Diarrhea, Constipation, Rectal bleeding, Change in Bowel habits, Jaundice, Ulcer/gallbladder disease, Hepatitis

URINARY TRACT: Kidney disease, Blood in urine, Frequency in urination, Renal stones

GENITO-REPRODUCTIVE SYSTEM:

MALE: Venereal disease history, Impotence,

Infertility FEMALE (Gynecological History):

Age of Menstruation _____ Last Period _____
Venereal disease history,
Serology
Last Pap_____Results _____

(Obstetric History):
Full-term deliveries_____ Pregnancies_____
Abortions_____Miscarriages_____Living Children _

Contraception Method_____Hysterectomy? _____

MUSCULOSKELETAL: Joint/Muscle Pain, Arthritis, Rheumatism, Swelling, Redness, Stiffness, Deformity, Muscle Pain

ENDOCRINE: Thyroid disease, Goiter, Hormone therapy, Diabetes

Mellitus PSYCHIATRIC:

Psychiatric Treatment Admission _____
Nervousness, Nervous Breakdown, Depression, Insomnia, Nightmares,

Memory Loss