CHARLES B. MALLETT, M.D.

New Patient Evaluation

Name: _____ Date of Exam: _____

Referred by: _____ Date of Birth: _____

Reason for your visit:

List your primary complaints or concerns:
(Please limit these to two per visit so that we can provide adequate attention to each issue)

_____

_____

Specialists:

Name	Type of Specialty
_____	_____
_____	_____
_____	_____

Past Medical History:

A. List all medications you are currently taking (including Over-the-Counter)

Name	Dosage (Milligrams)	Times per Day
_____	____	___
_____	____	___
_____	____	___
_____	____	___
_____	____	___
_____	____	___

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Past Medical History (Continued):

B. Medications/ Allergies **Reaction**

_____ _____

_____ _____

_____ _____

C. Pharmacy Information:

Local: _____ **Phone:** _____

Mail-Order: _____ **Phone:** _____

D. Operations/Procedures **Date**

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

E. Previous Illnesses (e.g. Diabetes, Hypertension, Hospitalizations) **Date**

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

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Family History:

	Illness	Age When Diagnosed
Mother	_____	_____
☐ Living ☐ Deceased (Age ____)	_____	_____
Father	_____	_____
☐ Living ☐ Deceased (Age ____)	_____	_____
Brother(s)	_____	_____
☐ Living ☐ Deceased (Age ____)	_____	_____
Sister(s)	_____	_____
☐ Living ☐ Deceased (Age ____)	_____	_____
Maternal Grandmother	_____	_____
☐ Living ☐ Deceased (Age ____)	_____	_____
Maternal Grandfather	_____	_____
☐ Living ☐ Deceased (Age ____)	_____	_____
Paternal Grandmother	_____	_____
☐ Living ☐ Deceased (Age ____)	_____	_____
Paternal Grandfather	_____	_____
☐ Living ☐ Deceased (Age ____)	_____	_____

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Social History:

Spousal Status: Married ☐ Partnered ☐ Single ☐ Widowed ☐

Living Arrangement: Live Alone ☐ Live with Other(s) ☐ With Whom? _____

Children: Yes ☐ No ☐ Number: _____ Ages: _____

Exercise:	Days per Week	Type	How Long Per Session?
	_____	_____	_____

Occupation: _____

Hobbies (How Do You Spend Your Free Time?)

_____

Have You Ever Smoked Tobacco? Yes ☐ No ☐

Do You Smoke Tobacco Now?	Yes ☐ No ☐	Packs/Day	# of Years
		_____	_____

Have You Ever Chewed Tobacco? Yes ☐ No ☐

If Yes, What Year Did You Quit Chewing/Smoking Tobacco? _____

Do You Drink Alcohol?	Yes ☐ No ☐	Beverages per Day	per Week
		____	____

Have You Ever Had a Blood Transfusion? Yes ☐ No ☐

Have You Ever Used Recreational Drugs? Yes ☐ No ☐

If yes, which drugs? _____

Have You Ever Been Exposed to HIV? Yes ☐ No ☐

Have You Recently Traveled Out of the Country? Yes ☐ No ☐

If Yes, where? _____

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Review of Systems:

Please circle if you have recently had problems with any of the following:

General:

☐ Weight Gain How much? _____ Over how long? (_____)
☐ Weight Loss How much? _____ Over how long? (_____)
☐ Fatigue ☐ Fever ☐ Night Sweats ☐ Heat or Cold Intolerance

Skin:

☐ Rash ☐ Hair Loss ☐ Easy Bruising ☐ Toenail Infection

Eyes:

☐ Redness ☐ Pain ☐ Discharge ☐ Dryness ☐ Visual Changes

Ears:

☐ Hearing ☐ Ringing ☐ Pain ☐ Discharge

Nose:

☐ Nose Bleed ☐ Sinus Congestion/Pain ☐ Nasal Discharge/Drainage

Mouth:

☐ Oral Lesions ☐ White Patches ☐ Bleeding Gums ☐ Toothache

Throat:

☐ Hoarseness ☐ Sore Throat ☐ Pain/Difficulty Swallowing

Respiratory:

☐ Cough ☐ Coughing Blood ☐ Shortness of Breath at Rest
☐ Shortness of Breath on Exertion ☐ Wheezing

Cardiovascular:

☐ Chest Discomfort ☐ Palpitations (Heart Fluttering or Racing)
☐ Ankle Swelling ☐ Rapid Heartbeat
☐ Difficulty Breathing When Lying Down ☐ Awakening Short of Breath

Urinary:

☐ Pain with Urination ☐ Urinating Frequently
☐ Urination at Night ☐ Difficulty Starting a Urine Stream
☐ Urinating Before You Can Get to the Bathroom
☐ Incontinence (Losing Your Urine) with Coughing/Laughing

Gastrointestinal:

☐ Nausea/Vomiting ☐ Diarrhea ☐ Blood in the Stool
☐ Black, Tarry Stool ☐ Heartburn/Reflux ☐ Constipation

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Musculoskeletal:

☐ Back Pain ☐ Muscle Pain
☐ Joint Pain or Stiffness: ☐ Which Joints? _____
☐ Joint Swelling or Redness: Which Joints? _____

Sexual:

☐ Decreased Libido ☐ Difficulty Achieving and Maintaining an Erection
Are You Sexually Active? Yes ☐ No ☐
If Yes, Are Your Partners: Men ☐ Women ☐ Both ☐
How Many Partners Have You Had in the Last Year? _____
Do You Use Safe Sexual Practices? Yes ☐ No ☐

Neurological:

☐ Seizures ☐ Difficulty with Balance ☐ Severe or Frequent Headaches
☐ Difficulty Walking ☐ Lightheadedness ☐ Fainting/Losing Consciousness
☐ Difficulty with Memory ☐ Vertigo (World Spinning Around You)
☐ Weakness: Which Parts of Your Body? _____

Psychological:

☐ Depression
☐ Desire to End Your Life ☐ Disabling Anxiety ☐ Panic Attacks
☐ Decreased Sense of Self-Worth ☐ Difficulty Focusing or Concentrating
☐ Lack of Interest in and Enjoyment of Activities That Used to Bring Pleasure

Sleep:

☐ Difficulty Getting to Sleep ☐ Difficulty Staying Asleep
☐ Snoring ☐ Cessation of Breathing during Sleep (As Reported by Bed Partner)

Women:

Date of Last Menstrual Period: _____
How Many Days Do Your Periods Last? _____
Age of First Period: _____
Are Your Periods: Every Month ☐ Irregular ☐
Number of Pregnancies:_____ Live Births: _____ Miscarriages: _____
Type of Contraception Used: _____

Men:

Date of Last Prostrate Exam: _____
Date of Last PSA Test: _____

Do You Have a Living Will or Advanced Directive? Yes ☐ No ☐
(If Yes, please provide a copy)

PRINT