



## NEW PATIENT H & P

<b>Patient Name</b> _____	<b>SSN</b> _____
<b>Reason for seeing Dr. Bershof?</b> _____ _____	
<b>Consulted other doctors about this?</b> No _____ Yes _____	
If "Yes", please list their names: _____	

<b>General Health:</b> Good _____ Fair _____ Poor _____					
If not "Good", please explain: _____ _____					
<b>Height</b> _____	<b>Weight</b> _____	<b>Recent Weight Change?</b> _____	<b>lbs.</b>	<b>Loss</b> _____	<b>Gain</b> _____
<b>Last physical exam by your physician</b> _____			<b>Name of physician</b> _____		
<b>Physician Address</b> _____			<b>Office Phone</b> _____		

<b>Illnesses (Please List)</b>			
Illness	Year	Hospital	Physician
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

<b>Previous Surgery (Please List)</b>				
Operation	Year	Surgeon	Hospital	Anesthesia
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

<b>Injuries (Please List)</b>				
Type	Year	Physician	Hospital	Result
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Relationship to Patient: \_\_\_\_\_  
 Print Name: \_\_\_\_\_  
 Signature: \_\_\_\_\_  
 Date: \_\_\_\_\_

I hereby acknowledge that I am aware of this office's **Notice of Privacy Practices**. Additionally, if I am not the patient, by signing I am acknowledging that I am guardian of the minor, the legal guardian of the minor, or the guardian/conservator of an incompetent patient who is unable to sign. I also give permission for Dr. Bershof and his office to communicate with my physicians and also the referring doctor.

**Women Only:**

Are you still menstruating? Yes \_\_\_ No \_\_\_

Bleeding between periods? Yes \_\_\_ No \_\_\_

Heavy bleeding with periods? Yes \_\_\_ No \_\_\_

Are you pregnant? Yes \_\_\_ No \_\_\_

Could you be pregnant? Yes \_\_\_ No \_\_\_

Plan future pregnancies? Yes \_\_\_ No \_\_\_

Last breast exam? \_\_\_\_\_

Last mammogram? \_\_\_\_\_

Are your mammograms normal? Yes \_\_\_ No \_\_\_

Pregnancies Children \_\_\_\_\_

Miscarriages Abortion \_\_\_\_\_

Complications of Pregnancies? \_\_\_\_\_

**Please Circle if you have or have had any of the following:**

Stroke	Cancer	Tuberculosis
Leukemia	Bronchitis	Seizure
Pneumonia	Diabetes	Hepatitis
Arthritis	Migraine	Hay Fever
Colitis	Goiter	Thyroid Disease
Slow/Poor Healing	Rash/Dermatitis	Bladder Infection
Blood Transfusion	Psychiatric Care	Numbness
Paralysis	Asthma	Heart Attack
Heart Disease	Ulcers	Kidney Disease
Tonsillitis	Rheumatic Heart	Scarlet Fever
Easy Bruising	Bleeding Tendency	Congenital Heart
High Blood Pressure	Anxiety Disorder	HIV+
AIDS	Shortness of Breath	Back Trouble
Poor Reaction Tape	Reaction to Anesthesia	Glaucoma
Cataracts	Keloids	Large Scars
Boils	Frequent Colds	Drug Addiction

**Please explain any of the above Circled in more detail:**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Please list any drug allergies:**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Please list all medications including prescription, over-the-counter drugs, vitamins, pain meds, aspirin, etc.:**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Daily Consumption of:**

Coffee \_\_\_\_\_ Alcohol \_\_\_\_\_ Tobacco \_\_\_\_\_ Recreational Drugs \_\_\_\_\_

Does anyone in household smoke? \_\_\_\_\_