NEW PATIENT H & P

Patient Name_____ **SSN**_____

Reason for seeing Dr. Bershof ?_____

_____

Consulted other doctors about this ? **No**_____ **Yes**_____

If "Yes", please list their names:_____

General Health: **Good**_____ **Fair**_____**Poor**_____

If not "Good", please explain:_____

_____

_____

Height_____ **Weight**_____ **Recent Weight Change?** _____**lbs.** **Loss** ____**Gain** _____

Last physical exam by your physician_____**Name of physician**_____

Physician Address _____**Office Phone** _____

Illnesses (Please List)

Illness	Year	Hospital	Physician

Previous Surgery (Please List)

Operation	Year	Surgeon	Hospital	Anesthesia

Injuries (Please List)

Type	Year	Physician	Hospital	Result

See back

Daily Consumption of:

Coffee_____ Alcohol_____ Tobacco_____ Recreational Drugs_____

Does anyone in household smoke? _____

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

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Please list any drug allergies:

_____ _____ _____

_____ _____ _____

_____ _____ _____

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:

_____

_____

_____

_____

_____

_____

_____

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?_____

_____

_____

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 either the parent 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.

Print Name: _____ **Signature:** _____ **Date:** _____

Relationship to Patient: _____