Dr. Lucio Pavone
New Patient Medical History Form

Consult Date: _____/_____/_____ Date of Birth: _____/_____/_____

Name: _____ Current Age: _____

Primary Care Physician _____ Primary Care Physician Phone # (_____)_____-_____

Referring Physician _____ Referring Physician Phone # (_____)_____-_____

Reason for visit: _____

Please list any medical conditions that you are currently being treated for:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

Please list any operation which you have undergone including removal of skin lesions:

Surgery	Year	Complications?

Do you have any allergies to food or medications? ☐ Yes ☐ No

If yes, please list your allergies below:

1._____ 2. _____ 3. _____ 4. _____

Please list any medications along with the doses that you are taking (including vitamins, herbal supplements, and aspirin or over the counter medications):

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

H _____ W _____ BMI _____ BSA _____ SSS _____

Do you currently smoke or use tobacco products? ☐ Yes ☐ No
If yes: How many packs do you smoke per day? _____
How many years have you smoked? _____

Do you drink alcohol? ☐ Yes ☐ No
If yes: How many drinks per week? _____

Do you use recreational drugs?
If yes, please list _____

Marital status: (Please circle one) Single / Married / Widowed / Divorced

Do you have any children? ☐ Yes ☐ No
If yes, how many? _____

Occupation: _____

Family History

Father: Living / Deceased If deceased, Cause of death: _____

Age: _____ Medical Conditions: _____

Mother: Living / Deceased If deceased, Cause of death: _____

Age: _____ Medical Conditions: _____

Please list any siblings and their medical conditions below:

Brother or sister (Please circle)	☐Alive ☐Deceased	Age:	Medical Conditions:
Brother or sister (Please circle)	☐Alive ☐Deceased	Age:	Medical Conditions:
Brother or sister (Please circle)	☐Alive ☐Deceased	Age:	Medical Conditions:
Brother or sister (Please circle)	☐Alive ☐Deceased	Age:	Medical Conditions:
Brother or sister (Please circle)	☐Alive ☐Deceased	Age:	Medical Conditions:

Please circle any of the symptoms that you are currently experiencing:

GENERAL

Fever	Yes
Chills	Yes
Night Sweats	Yes
Fatigue	Yes
Weakness	Yes
Change in Appetite	Yes
Weight Loss	Yes
Weight Gain	Yes

ENDOCRINE

Poor/Slow Wound Healing	Yes
Weight loss/gain	Yes
Fertility/hormone problems	Yes
Cold Intolerance	Yes
Heat Intolerance	Yes
Excessive Thirst	Yes
Thyroid Disease	Yes

EYES, EARS, NOSE, THROAT

Ear Pain	Yes
Ear Drainage	Yes
Hearing loss	Yes
Visual changes	Yes
Double Vision	Yes
Cataracts	Yes
Glaucoma	Yes
Nasal Congestion	Yes
Nose Bleeds	Yes
Hoarseness	Yes
Sore throat	Yes
Swollen Glands	Yes

RESPIRATORY

Shortness of breath	Yes
Cough	Yes
Bloody Cough	Yes
Phlegm	Yes
Asthma	Yes
Wheezing	Yes
Chest pain	Yes
Chest Pressure	Yes
Palpitations	Yes
Irregular Heartbeat	Yes
High blood pressure	Yes
Stroke	Yes
Leg Swelling	Yes

BREAST

Breast Masses	Yes
Breast Pain	Yes
Change in Skin	Yes
Skin Dimpling	Yes
Nipple Discharge	Yes
Rash	Yes

GASTROINTESTINAL

Difficulty Swallowing	Yes
Pain	Yes
Reflux Symptoms	Yes
Nausea/Vomiting	Yes
Diarrhea	Yes
Heartburn	Yes
Bloody Stools	Yes
Constipation	Yes
Change in Bowel habits	Yes
Abdominal Pain	Yes

GENITOURINARY

Frequent urination	Yes
Nighttime urine	Yes
Hesitancy/retaining urine	Yes
Painful Urination	Yes
Incontinence	Yes
Decrease Urine Stream	Yes
Blood in Urine	Yes
Vaginal/Penile Discharge	Yes

SKIN

Rashes	Yes
Itching	Yes
Skin Lesions	Yes
Dry Skin	Yes
Changes in skin/color	Yes
Changes in Moles	Yes
Sunburns	Yes
Sunburns with Blistering	Yes

HEMATOLOGIC/ LYMPHATIC

Easily Bruising/bleeding	Yes
Swollen Glands	Yes
Swollen Lymph nodes	Yes
Bleeding disorders	Yes
Blood Clots	Yes
Pulmonary Emboli	Yes

GYNECOLOGIC

Irregular Menses	Yes
Pelvic Pain	Yes
Pain with intercourse	Yes
Painful Menses	Yes
Pregnancy	Yes

MUSCULOSKELETAL

Muscle ache/pain	Yes
Joint Pain	Yes
Stiff Joints	Yes
Neck Pain	Yes
Back Pain	Yes
Bone Pain	Yes

NEUROLOGIC

Headaches	Yes
Migraines	Yes
Seizure/epilepsy	Yes
Speech problems	Yes
Coordination Problems	Yes
Tremors/Trembling	Yes
Fainting/Black outs	Yes
Memory problems	Yes
Loss of sensation/numbness	Yes
Problems Walking	Yes
Weakness	Yes
Tingling/Burning hands/feet	Yes

PSYCHIATRIC

Abusive relationship	Yes
Bipolar Disorder	Yes
Sleep Disturbance	Yes
Anxiety	Yes
Depression	Yes
Feeling of Despair	Yes

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By signing below, I further authorize the use of the Medical Photos for professional medical purposes, including but not limited to, medical education that I will not be entitled to any monetary payment or any other compensation for the use of these Medical Photos.

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I understand my right to refuse authorization for the taking of Medical Photos; and my right to refuse release of such Medical Photos.

PATIENT NAME PRINTED: _____

PATIENT SIGNATURE:

_____

WITNESS: _____ DATE: _____/_____/_20_____