Pat T. Tidwell, M.D., P.A.
4554 East Hwy 20 Suite 100
Niceville, FL 32578

NEW PATIENT HISTORY FORM

Today's date:_____ Patient Name:_____ DOB:_____
Insurance:_____Insurance card provider? YES NO
Which provider did you see?_____ Date of last visit: _____
Consent to download prescription history: YES NO Pharmacy:_____
Chief Complaint:_____
Please tell us why you are here today:_____
_____
_____
Who was your previous doctor? _____
Date last seen: _____

PAST MEDICAL HISTORY: Do you or have you ever had.....(circle yes or no)

Arthritis YES NO	Diabetes YES NO	Hypertension YES NO	Stroke YES NO
Asthma YES NO	Gout YES NO	Kidney disease YES NO	Thyroid disease YES NO
Blood clots YES NO	HIV YES NO	Liver disease YES NO	Ulcer/GERD YES NO
COPD YES NO	Heart disease YES NO	Pneumonia YES NO	Cancer YES NO
Cataract YES NO	Hepatitis YES NO	Bronchitis YES NO	Type:

Please list other illnesses: _____
_____
_____

Have you had any serious injuries? Yes No If yes, please describe: _____
_____

Have you had you influenza vaccine?_____ When and where?_____
Have you had your pneumonia vaccine?_____When and where?_____

PAST SURGICAL HISTORY: (List all previous operations)
_____
_____
_____

CURRENT MEDICATIONS: (Please list all current medicines and dosage)
_____
_____
_____

DRUG ALLERGIES: (Please list all medicine you are allergic to)
_____
_____

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NEW PATIENT HISTORY FORM

SOCIAL HISTORY/HABITS:
Tobacco Use:
Are you a current cigarette smoker? YES NO If yes, _____ packs per day for _____ years.
If no, are you a former smoker? YES NO If yes, _____packs per day for _____ years.
Alcohol Use:
Beer:_____ drinks per week. Wine: _____ drinks per week. Liquor: _____ drinks per week.
Social drinks? _____. How often?_____

Marital Status (circle): Single Married Divorced Widow/widower
Occupation:_____
Have you ever been treated for alcoholism? YES NO
Have you ever used illegal drugs? YES NO
If YES, please specify which drugs: _____

FAMILY HISTORY:
Mother:_____Alive Deceased What Age_____
Father: _____Alive Deceased What Age_____
Siblings:_____Alive Deceased What Age_____
_____Alive Deceased What Age_____
Do you know of any other blood relative who has/had any of the following (please specify relationship)

Bleeding disorder_____	Stroke_____
Cancer_____	TB_____
Diabetes_____	Other_____
Heart disease_____	Other_____
Hypertension_____	Other_____
Mental Illness_____	Other_____

REVIEW OF SYSTEMS:
In the last 2 months, have you have any of the following? (circle)

Fever	YES	NO	Indigestion	YES	NO
Head injury	YES	NO	Nausea/vomiting	YES	NO
Impaired vision	YES	NO	Depression or anxiety	YES	NO
Hearing impairment	YES	NO	Hallucinations	YES	NO
Sinusitis	YES	NO	Rashes	YES	NO
Runny nose	YES	NO	Seizures	YES	NO
Cough	YES	NO	Weight gain	YES	NO
Wheezing	YES	NO	Weight loss	YES	NO
Short of breath	YES	NO	Bleeding easily	YES	NO
Chest pain	YES	NO	Blood clots	YES	NO
Palpitations	YES	NO	Swollen lymph nodes	YES	NO
Heart murmur	YES	NO	Pain on urination	YES	NO
Varicose veins	YES	NO	Urinary tract infections	YES	NO
Lower extremity swelling	YES	NO	Prostate problems (male)	YES	NO