

# Asheville Medicine & Pediatrics

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New Patient Medical History

Please fill out all sections completely.

PATIENT NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_/\_\_\_\_/\_\_\_\_

Please list ALL medications you are currently taking. Be sure to include strength and directions for use.

_____	_____	_____
_____	_____	_____
_____	_____	_____

Are you ALLERGIC TO ANY MEDICATION(S)? YES NO

If so, please list: \_\_\_\_\_

Please tell us about your medical history by checking the box beside any illness or condition that you now have or have had in the past.

## CARDIOVASCULAR

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> AORTIC ANEURISM         | <input type="checkbox"/> ARRHYTHMIA           | <input type="checkbox"/> CONGESTIVE HEART FAILURE |
| <input type="checkbox"/> CORONARY ARTERY DISEASE | <input type="checkbox"/> DEEP VEIN THROMBOSIS | <input type="checkbox"/> HIGH CHOLESTEROL         |
| <input type="checkbox"/> HIGH BLOOD PRESSURE     | <input type="checkbox"/> HEART ATTACK         | <input type="checkbox"/> PACEMAKER                |
| <input type="checkbox"/> VALVE PROBLEMS          | <input type="checkbox"/> HEART MURMUR         | <input type="checkbox"/> OTHER: _____             |

## PULMONARY

- |                                      |   |   |
|--------------------------------------|---|---|
| <input type="checkbox"/> ASTHMA      | <input type="checkbox"/> CHRONIC BRONCHITIS | <input type="checkbox"/> COPD/EMPHYSEMA         |
| <input type="checkbox"/> PNEUMONIA   | <input type="checkbox"/> PULMONARY EMBOLISM | <input type="checkbox"/> PULMONARY HYPERTENSION |
| <input type="checkbox"/> SLEEP APNEA | <input type="checkbox"/> TUBERCULOSIS       | <input type="checkbox"/> OTHER: _____           |

## GASTROINTESTINAL

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> CIRRHOSIS      | <input type="checkbox"/> COLON POLYPS         | <input type="checkbox"/> CROHN'S DISEASE          |
| <input type="checkbox"/> HEARTBURN/GERD | <input type="checkbox"/> HEPATITIS            | <input type="checkbox"/> IRRITABLE BOWEL SYNDROME |
| <input type="checkbox"/> PANCREATITIS   | <input type="checkbox"/> PEPTIC ULCER DISEASE | <input type="checkbox"/> OTHER: _____             |

## GENITOURINARY

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> RENAL FAILURE        | <input type="checkbox"/> ENLARGED PROSTATE        | <input type="checkbox"/> ENDOMETRIOSIS |
| <input type="checkbox"/> DIFFICULTY URINATING | <input type="checkbox"/> ERECTILE DYSFUNCTION     | <input type="checkbox"/> KIDNEY STONES |
| <input type="checkbox"/> INCONTINENCE         | <input type="checkbox"/> URINARY TRACT INFECTIONS | <input type="checkbox"/> OTHER: _____  |

## MUSCULOSKELETAL

- |                                       |   |  |
|---------------------------------------|---|--|
| <input type="checkbox"/> CHRONIC PAIN | <input type="checkbox"/> FIBROMYALGIA         | <input type="checkbox"/> BROKEN BONES: _____ |
| <input type="checkbox"/> GOUT         | <input type="checkbox"/> HIP REPLACEMENT      | <input type="checkbox"/> OSTEOARTHRITIS      |
| <input type="checkbox"/> OSTEOPOROSIS | <input type="checkbox"/> RHEUMATOID ARTHRITIS | <input type="checkbox"/> OTHER: _____        |

## ENDOCRINE/METABOLIC

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> DIABETES TYPE ONE | <input type="checkbox"/> DIABETES TYPE TWO | <input type="checkbox"/> DYSMETABOLIC SYNDROME |
| <input type="checkbox"/> HYPERTHYROIDISM   | <input type="checkbox"/> HYPOTHYROIDISM    | <input type="checkbox"/> OTHER: _____          |

## NEUROLOGICAL

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> ALZHEIMER'S DISEASE | <input type="checkbox"/> ADD/ADHD                      | <input type="checkbox"/> STROKE                   |
| <input type="checkbox"/> MIGRAINE HEADACHES  | <input type="checkbox"/> TENSION HEADACHES             | <input type="checkbox"/> TRANSIENT ISCEMIC ATTACK |
| <input type="checkbox"/> PARKINSONS DISEASE  | <input type="checkbox"/> PERIPHERAL SENSORY NEUROPATHY | <input type="checkbox"/> OTHER: _____             |

## BLOOD DISORDERS

- |  |   |                                       |
|--|---|---------------------------------------|
| <input type="checkbox"/> ANEMIA (PERNICIOUS OR IRON DEFF.) | <input type="checkbox"/> SICKLE SELL ANEMIA | <input type="checkbox"/> OTHER: _____ |
|--|---|---------------------------------------|

## ALLERGY/DERMATOLOGY/OTHER

- |   |                                   |   |
|---|-----------------------------------|---|
| <input type="checkbox"/> ALLERGIES                  | <input type="checkbox"/> ECZEMA   | <input type="checkbox"/> RECURRENT EAR INFECTIONS |
| <input type="checkbox"/> RECURRENT SINUS INFECTIONS | <input type="checkbox"/> INSOMNIA | <input type="checkbox"/> OTHER: _____             |

