Bernhoft Center For Advanced Medicine

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MEDICAL DIRECTOR

NEW PATIENT HISTORY FORM

NAME: _____ AGE: _____ DATE: _____ TIME: _____ am/pm

A. **MAJOR SYMPTOMS**: Please note that this is a comprehensive history. Details are important in understanding your problems and their causes. The time you take to fill this out is time well spent!

1. Tell us what are your **major symptoms** or problems for which you have come to us today and their duration.

2. For **how long** have you been having each symptom that you have listed above? If you have not already answered it above, please do so now by specifying the duration next to each symptom.

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B. TREATMENT RECEIVED

1. Number of physicians seen for the problems you have mentioned above, and their specialties:

2. Tell us about the **treatment you have received** for the problems you have mentioned above, such as investigators, and the tests that you had (including x-rays, CT scans, blood tests), and medicines used – prescription or over-the-counter medicines, etc.