Curtis Haskins, MD
curtishaskinsmd.com

6650 Rivers Avenue
North Charleston, SC 29406

Phone: 843-494-2411
843-576-5417
Fax: 843-410-2790

NEW PATIENT HISTORY FORM Date:_____

Name:_____ **Age**:_____ **DOB**:_____ Sex: M F

Address: _____
_____

Reason for Visit: _____

Email: _____

Emergency Contact Information: (please provide name, address, and phone number)
_____
_____
_____

PAST MEDICAL HISTORY

Have you ever had any of the following:

Check each item	No	Yes	Check each item	No	Yes	Check each item	No	Yes
Anemia/Blood Disorder			Gallstones			Lung Problems		
Anxiety			Gout			Neurological Disorder		
Arthritis			Headaches			Pneumonia		
Asthma			Heart Attack			Seizure Disorder		
Back/Neck Problems			Heart Valve Problems			Skin Disorder		
Blood Clotting Disorder			Hepatitis			Stomach/ Intestine Ulcer		
Cancer			High Blood Pressure			Stroke		
Coronary Artery Disease			High Cholesterol			Thyroid Disorder		
Depression			Kidney Disease			Tuberculosis		
Diabetes			Liver Problems			Anything Else ??		

Explanations for "Yes" answers:

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Are you? ☐right handed ☐left handed

Are you or have you ever been under care for pain management? ☐No ☐Yes
If Yes, ☐Currently ☐In the past

Pain Management Provider: _____

HOSPITALIZATIONS: ☐None Year Hospital

Illnesses: _____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Surgeries: _____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

HEALTH MAINTENANCE:
Have you ever had the following:

	Yes/No	Year	Results	Doctor
Cardiac Stress Test				
Colonoscopy				
Mammogram				
Pap Smear				
Bone Density Test				
Chest CT (if any history of smoking)				
Hepatitis Testing				
Tuberculosis				
Last Dental Exam				
Last Eye Exam				
Last Skin Exam				

IMMUNIZATIONS:

All childhood immunizations completed? No Yes

	No	Yes
Pneumonia		
Shingles		

Tetanus Shot		
Flu Shot		
Chickenpox (or had the disease)		
HPV		

CURRENT MEDICATIONS: ***(Include over-the-counter, supplements, and "as needed" meds)***

Name	**Strength**	**Frequency**
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

MEDICATION ALLERGIES:

Medication	**Reaction**
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	

Food and Environmental Allergies:_____

FAMILY HISTORY:

	No	**Yes**	**Family Member**		**No**	**Yes**	**Family Member**
Anesthesia problems				High Blood Pressure			
Bleeding problems				Osteoporosis			
Cancer Location:				Stroke			
Diabetes				Thyroid Disease			
Heart disease prior to age 60				Other Disease			

SOCIAL HISTORY:

Employer name: _____ Phone: _____
Employer Address: _____
_____

Occupation:_____ ☐Retired ☐Disabled ☐Unemployed

Marital Status: ☐Single ☐Married ☐Separated ☐Divorced ☐Widowed

Number of children: _____ Hobbies:_____

PERSONAL HABITS:

Do you…	**No**	**Yes**	**How much?**	**How long?**
Exercise Regularly?				
Use alcohol?				
Wear a seat belt?				
Use illegal drugs?				
Ever Smoked?				

Do you have a Healthcare Power of Attorney? ☐No ☐Yes

Please list your preferred pharmacies:

Primary:
Name: _____

Address:_____

Phone Number: _____

Secondary:
Name: _____

Address:_____

Phone Number: _____