Karen D. Miles MD PLLC
New Patient Form

First Name: ________________________ **Last Name:** ______________________________ **DOB:**______________________________

Mailing Address:____

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Primary Phone Number: ______________________________ **Email Address:** ____

Emergency Contact: __________________ Relationship: ________________________ Phone Number: _______________________

Insurance Policy Holder: ___________________________________ Insurance Policy Holder DOB: __________________________

Pharmacy: ____ Contact #: ___________________________________

Primary Care Doctor: ______________________________________ Contact #: ___________________________________

Legal Guardian (if any): __________________Relationship: ________________________ Phone Number: _______________________

Today Concerns (a brief description of what you would like to discuss today): ____

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Current Medications: Include current medication name, dose, time taken, efficacy and side effects on the chart below. Include all prescription medications, over the counter medications and herbal supplements.

Medication Name	Dose	Time Taken	Is Medication Effective?	Side Effects

Mediation Allergies:____

☐ Lab work performed in the last 6 months Facility where lab work was completed: ______________________________

Past Medical History: Include any major health concerns that may have affected consumer's mental health, relevant injuries and physical issues. Ex. Seizures, head injury, heart problems, asthma, etc.:

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Mental Health Treatment History (please provide dates): Include number of prior psychiatric hospitalization-specify number within past twelve months.

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Family Medical and Psychiatric History: Has any immediate family member (parent, grandparent, or sibling) experienced any of the following conditions? If Yes, please list relationship.:

Heart Condition:	☐ NO	☐ YES__________	Eating Disorder:	☐ NO	☐ YES___________
High Blood Pressure:	☐ NO	☐ YES__________	Depression:	☐ NO	☐ YES___________
Diabetes:	☐ NO	☐ YES__________	Schizophrenia:	☐ NO	☐ YES___________
High Cholesterol:	☐ NO	☐ YES__________	Substance Abuse:	☐ NO	☐ YES___________
Anxiety:	☐ NO	☐ YES__________	Suicide Attempt:	☐ NO	☐ YES___________
ADD/ADHD:	☐ NO	☐ YES__________	Suicide Completed:	☐ NO	☐ YES___________
Bipolar Disorder:	☐ NO	☐ YES__________	Heart Related Sudden Death before age 50:	☐ NO	☐ YES___________
Psychiatric Hospitalization:	☐ NO	☐ YES__________			

Review of Systems: Check any system experienced within the last 30 days.

System				
Constitutional Symptoms	☐ Fever	☐ Chills	☐ Weight Loss	☐ Fatigue
	☐ Weight Gain	☐ Night Sweats	☐ Sleep Problems	
Eyes	☐ Vision Changes	☐ Blurry Vision	☐ Double Vision	
	☐ Glasses	☐ Contact Lenses		
Ear, Nose, Mouth and Throat	☐ Runny Nose	☐ Nose Bleeds	☐ Sinus Pain	☐ Ear Pain
	☐ Sinus Congestion	☐ Ringing in Ears	☐ Bleeding Gums	
	☐ Dizziness	☐ Sore Throat	☐ Pain in Swallowing	
Cardiovascular Respiratory	☐ Chest Pain	☐ Shortness of Breath	☐ Palpitations	☐ Fainting
	☐ Cough	☐ Wheezing	☐ Coughing up Blood	
Gastrointestinal	☐ Abdominal Pain	☐ Difficulty Swallowing	☐ Nausea	☐ Diarrhea
	☐ Vomiting	☐ Constipation	☐ Changes in Stool	
	☐ Bloating	☐ Heartburn	☐ Decreased Appetite	
Genitourinary	☐ Urinary Frequency	☐ Pain During Urination	☐ Incontinence	☐ Kidney Stones
	☐ Discharge	☐ Pelvic Pain	☐ Problems with Menstruation	
Musculoskeletal	☐ Joint Pain	☐ Joint Stiffness	☐ Joints Swelling	☐ Arthritis
Integumentary	☐ Rashes	☐ Sores	☐ Dry Skin	
	☐ Itchy Skin	☐ Acne	☐ Breast Problems	
Neurological	☐ Headache	☐ Limb Weakness	☐ Limb Numbness	
	☐ Seizures	☐ Balance Problems	☐ Pins and Needles Sensation	
Psychiatric	☐ Nervousness	☐ Mood Changes	☐ Depression	
Endocrine	☐ Thyroid Problems	☐ Heat Intolerance	☐ Cold Intolerance	☐ Tremor
	☐ Nail Changes	☐ Hair Changes	☐ Excessive Thirst	☐ Dry Skin
Hematologic/Lymphatic Allergic/Immunologic	☐ Anemia	☐ Easy Bruising	☐ Swollen Glands	
	☐ Frequent Illnesses	☐ Allergy Symptoms	☐ Hay Fever	