New Patient Questionnaire

Patient Name: _____Date:_____

What is the reason for your visit today?_____

Who was your previous Primary Care Physician? _____

PAST MEDICAL HISTORY: Have you ever had any of the following? Please circle all that apply.

_____Anemia
_____Arthritis: Gout____Rheumatoid____
_____Asthma
_____Cancer, specify type_____
_____Depression or Anxiety
_____Diabetes
_____Diverticulitis
_____Emphysema
_____Epilepsy
_____Excessive Bleeding
_____Muscles, Bones, Joints: Specify_____
_____Glaucoma
_____Thyroid disease
_____Hiatal Hernia or GE Reflux
_____High Blood Pressure
_____Heart Attack
_____Coronary Artery Disease
_____Hepatitis
_____Kidney Stones
_____Kidney Disease
_____Liver Disease
_____Migraine Headache
_____Neurological Disease
_____Osteoporosis
_____Polyps in Colon
_____Pneumonia
_____Rheumatic fever
_____Sickle Cell Anemia or Trait
_____Stroke
_____Tuberculosis
_____Ulcers

Any other pertinent past medical history you wish to nclude?_____

PAST SURGICAL HISTORY: Have you had any of the following surgeries? If yes, put year. If no, leave blank.

_____Tonsils
_____Appendix
_____Cataract ___Right___Left___Both
_____Gallbladder
_____Hemorrhoids
_____Other, please specify_____
_____Hernia Type_____
_____Hysterectomy
_____Tubes and Ovaries
_____Prostate
_____Mastectomy
_____Tubal Ligation
_____Coronary Bypass
_____Kidney
_____Thyroid
_____Muscles, Bones or Joints
Specify joint_____

SOCIAL HISTORY

Do you drink alcohol?_____ If yes, estimate the number of drinks, beers, or glasses of wine per week?
_____
Have you ever smoked?_____ If yes, current?_____How many packs per day? _____How many years?_____
Have you ever used any illegal drugs?_____ If yes, what kind
taken?_____
Do you exercise regularly? _____ How often and for how long? _____

FAMILY HISTORY:

Mother: Age:_____ Alive___Deceased___ Cause of Death_____
Father: Age:_____Alive___Deceased___ Cause of Death_____
Brothers: Age(s)_____Alive___Deceased___ Cause of Death_____
Sisters: Age(s)_____Alive___Deceased___ Cause of Death_____

Did any *blood relatives* (parents, grandparents, children, brothers or sisters) have any of the following? If so, please state who:

Arthritis_____ Other Cancer_____ Heart Disease_____
Asthma_____ Diabetes_____ Stroke_____
Breast Cancer_____ Excessive Bleeding_____ Tuberculosis_____
Colon Cancer_____ High Blood Pressure_____ Kidney Disease_____
Other:_____

PRESENT MEDICATIONS: List all current medications and doses including over the counter medications and vitamins.

_____

_____

MEDICATION ALLERGIES: Please list any medication allergies you have and the kind of reaction for each.

_____

_____