

NEW PATIENT QUESTIONNAIRE

Name: _____ Age: _____ Date: _____

Reason for your visit today: _____

Other physicians you have seen: _____

Past History: (Please include all your health problems, such as asthma, diabetes, heart disease, high blood pressure:

Surgical operations/ Procedures:

Please list all the operations and procedures you have had, such as heart bypass, angioplasty, cardiac catheterization, appendix removal, etc.:

_____	Year	_____	Year
_____	Year	_____	Year
_____	Year	_____	Year
_____	Year	_____	Year

Allergies:

Please check on the line for any allergies that you know about:

_____ Aspirin	_____ Codeine	_____ Penicillin
_____ Anesthetics	_____ Demerol	_____ Sulfa Drugs
_____ Other than on list _____		

Do you smoke? Yes ___ No ___ Have you ever smoked? _____ How Long? _____ Quit _____

Medications:

Please list all medications you are currently taking with mg and how many times a day you take it. (Example: Toprol XL 50mg one tab daily)

How much aspirin do you take each day (if any)? _____

Do you take birth control pills? _____

Hobbies and activities _____

Exercise:

Type: _____ Frequency: _____

Please turn page over

Please check any problems you are having currently:

- | | |
|---|--|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Numbness in hands or feet | <input type="checkbox"/> Bloody bowel movements |
| <input type="checkbox"/> Difficulty in balance | <input type="checkbox"/> Black bowel movements |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Abdominal pain |
| <input type="checkbox"/> Fainting | <input type="checkbox"/> Jaundice |
| <input type="checkbox"/> Ringing in ears | <input type="checkbox"/> Hemorrhoids |
| <input type="checkbox"/> Difficulty hearing | <input type="checkbox"/> Weight loss |
| <input type="checkbox"/> Double vision | <input type="checkbox"/> Weight gain |
| <input type="checkbox"/> Excessive sneezing | <input type="checkbox"/> Loss of appetite |
| <input type="checkbox"/> Nasal congestion | <input type="checkbox"/> Trouble sleeping |
| <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Difficulty thinking |
| <input type="checkbox"/> Nose bleeds | <input type="checkbox"/> Frequent urination |
| <input type="checkbox"/> Swelling of feet or ankles | <input type="checkbox"/> Pain with urination |
| <input type="checkbox"/> Palpitations of the heart | <input type="checkbox"/> Blood in urine |
| <input type="checkbox"/> Chest pain or tightness | <input type="checkbox"/> Reduction in urine |
| <input type="checkbox"/> Change in shoe size | <input type="checkbox"/> Difficulty urinating |
| <input type="checkbox"/> High blood cholesterol | <input type="checkbox"/> Leakage of urine |
| <input type="checkbox"/> Excessive thirst | <input type="checkbox"/> Stiff neck |
| <input type="checkbox"/> Chronic fatigue | <input type="checkbox"/> Back pain |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Pain in legs when walking |
| <input type="checkbox"/> Swelling of the legs | <input type="checkbox"/> Joint pain |
| <input type="checkbox"/> Cough | <input type="checkbox"/> Loss of hair |
| <input type="checkbox"/> Coughing up blood | <input type="checkbox"/> Skin rash |
| <input type="checkbox"/> Wheezing | <input type="checkbox"/> Dry skin |
| <input type="checkbox"/> Night Sweats | <input type="checkbox"/> Hives |
| <input type="checkbox"/> Fever more than 5 days | <input type="checkbox"/> Itchiness |
| <input type="checkbox"/> Difficulty swallowing | <input type="checkbox"/> Pain with intercourse |
| <input type="checkbox"/> Vomiting | <input type="checkbox"/> Mood swings |
| <input type="checkbox"/> Anxiety/Nervousness | <input type="checkbox"/> Drug use _____ |
| | <input type="checkbox"/> Alcohol use _____ |

Family History:

Please include age, health status, and cause of death (if deceased):

Father: _____

Mother: _____

Brother(s): _____

Sister(s): _____

Thank you for taking the time to complete our form. This will help us to review your history more completely.