Name: _______________________________________ **Today's Date:** ___________________

New Patient Questionnaire

Last Name	First Name		M.I.
Date of Birth (mm/dd/yyyy)	**Social Security Number**	**Contact Phone Number**	
Marital Status	**Name of Spouse**		
Next of Kin or Emergency Contact (Name & Telephone)			

Names of Children

Other Physicians Currently Involved in Your Care

Your Health History *(Personal)*

*Check if **you** have had any of the following*

☐ High Cholesterol	☐ Diabetes	☐ Asthma	☐ Heartburn/ GERD
☐ High Blood Pressure	☐ Thyroid Disease	☐ Emphysema/ COPD	☐ Stomach Ulcers
☐ Stroke	☐ Gout	☐ Hx of Pneumonia	☐ Gallbladder Disease
☐ Heart Failure	☐ Osteoporosis	☐ Hx of Tuberculosis	☐ Hepatitis
☐ Atrial Fibrillation	☐ Arthritis	☐ Hx of Syphilis	☐ Colitis or Crohn's
☐ Abn. Heart Rhythm	☐ Back Pain	☐ Hx of an STD	☐ Diverticulitis
☐ Obesity	☐ Anxiety/ Stress	☐ Kidney Stones	☐ Irritable Bowel Syn.
☐ Valvular Heart Dis.	☐ Depression	☐ Chronic Kidney Disease	☐ HIV/AIDS
☐ Peripheral Vascular Dis.	☐ Headaches/ Migraines	☐ Seizures/ Epilepsy	☐ Cancer (any type)

Preventive Health History

*Check if **you** have had any of the following preventive health screening exams. If so, when (mm/yyyy)?*

☐ *Rectal Exam* *Approx. Date* _____________
☐ Flexible Sigmoid. Approx. Date _____________
☐ Colonoscopy Approx. Date _____________
☐ PSA Blood test Approx. Date _____________
☐ Cardiac Stress test Approx. Date _____________

Females:
☐ Pelvic and PAP Approx. Date ________________
☐ Mammogram Approx. Date ________________
☐ Breast Exam Approx. Date ________________
☐ Bone Density Approx. Date ________________

Accidents – Trauma

Have **you** ever had a severe accident? ☐ Fractures ☐ Trauma ☐ Other ____
Do you have any metal pins or plates in your body: ☐ Yes ☐ No If so, where? ________________________________

Immunization History

Check if **you** have had any of the following immunizations. If so, when?

☐ Tetanus (Td) Approx. Date ___________________
☐ Pneumovax Approx. Date ___________________
☐ Hepatitis B Approx. Date ___________________
☐ Influenza (Flu) Approx. Date ___________________

Name: ____ **Today's Date:** ____________________

Allergies to Medications

☐ Allergies - List: ____

____

Past Medical History

List ALL previous **chronic medical conditions, hospitalizations, and past surgeries** with the approximate month and year as best as you can recall

Problem	Date	Problem	Date

List ALL prescription medications you are currently taking with their dosage and frequency:

Medication	Dose	Frequency	Medications	Dose	Frequency

Health Habits

Your level of exercise is: ☐ Sedentary - Almost never ☐ Occasional ☐ More than 3x/week ☐ Almost daily

Do you try and follow a healthful diet? ☐ Yes ☐ No Describe: ____

Do you now or have you ever smoked cigarettes, cigars, pipes? ☐ Yes ☐ No
How much do/did you smoke? (packs per day) ______________ How long have you smoked (years)? ________________
Did you quit smoking? _________ ☐ Yes ☐ No If so, when? ____________________________________

Do you drink alcoholic beverages? ☐ Yes ☐ No If so, how many per week? ______________________________

Family History

Check if any of your first-degree relatives have or have had any of the following:

☐ Breast Cancer
☐ Colon Cancer
☐ Prostate Cancer
☐ Lung Cancer
☐ Skin Cancers
☐ Stomach Ulcers
☐ Colitis / Crohn's Dis
☐ High Blood Pressure
☐ Heart Attack
☐ Stroke
☐ High Cholesterol
☐ Heart Failure
☐ Migraine Headaches
☐ Anxiety / Panic disorder
☐ Diabetes
☐ Thyroid disease
☐ Gout
☐ Arthritis
☐ Osteoporosis
☐ Kidney Stones
☐ Bleeding Disorder
☐ Colon Polyps
☐ Liver Disease
☐ Suicide / Mental Illness
☐ Alcoholism
☐ Leukemia
☐ Sickle Cell disease

Name: ____ **Today's Date:** ____________________

Immediate Family Members Health History

	Name of Member	Current Age	Health Status	Known Illnesses	Age & Cause of death* (*only if deceased)
Mother					
Father					
Sibling					
Sibling					
Sibling					
Sibling					

Systems Review

Please check each item "yes" or "no as they relate to your health.

Constitutional	Yes	No
Weight loss	☐	☐
Fatigue	☐	☐
Fever or Sweats	☐	☐
Headache	☐	☐
Eyes		
Glasses/Contacts	☐	☐
Cataracts	☐	☐
Double Vision	☐	☐
Glaucoma	☐	☐
Ears, Nose,Throat		
Difficulty Hearing	☐	☐
Ringing in Ears	☐	☐
Vertigo	☐	☐
Sinus Pain	☐	☐
Nasal Congestion	☐	☐
Frequent Sore Throats	☐	☐
Hoarseness	☐	☐
Cardiovascular		
Chest pain	☐	☐
Palpitations	☐	☐
Fainting Spells	☐	☐
Dizziness	☐	☐
Difficulty Lying Flat	☐	☐
Swelling in Legs	☐	☐
Cramps or Coldness in Legs	☐	☐

Respiratory	Yes	No
Cough	☐	☐
Coughing Blood	☐	☐
Wheezing	☐	☐
Shortness of Breath	☐	☐
Gastrointestinal		
Heartburn	☐	☐
Nausea/Vomiting	☐	☐
Constipation	☐	☐
Diarrhea	☐	☐
Difficulty Swallowing	☐	☐
Abdomen Pain	☐	☐
Black Stools	☐	☐
Genitourinary		
Frequent Urination	☐	☐
Difficult Urination	☐	☐
Burning on urination	☐	☐
Nighttime Frequency	☐	☐
Blood in Urine	☐	☐
Abnormal Discharge	☐	☐
Genital Skin Lesions	☐	☐
Endocrine		
Loss of Hair	☐	☐
Heat/Cold Intolerance	☐	☐
Weight Gain	☐	☐
Sexual Dysfunction	☐	☐

Lymph/Immune	Yes	No
Easy Bruising	☐	☐
Gums Bleed Easily	☐	☐
Enlarged Glands	☐	☐
Hay Fever/Allergies	☐	☐
Musculoskeletal		
Joint Pain/Swelling	☐	☐
Back Pain	☐	☐
Muscle Pain	☐	☐
Skin		
Rash/Sores	☐	☐
Abnormal Moles	☐	☐
Abnormal Masses	☐	☐
Neurological		
Seizures	☐	☐
Weakness/Paralysis	☐	☐
Numbness	☐	☐
Tremors	☐	☐
Memory Loss	☐	☐
Psychiatric		
Mood Swings	☐	☐
Difficulty Sleeping	☐	☐
Anxiety/Depression	☐	☐
Females only		
Heavy/Irregular Periods	☐	☐
Vaginal Discharge	☐	☐
Infertility	☐	☐
Hot Flashes	☐	☐

Please explain or comment on any **Yes** response if you feel more details are needed.

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