New Patient Questionnaire

Name:_____ DOB:_____ Date:_____

Healthcare Specialists:

Specialist-Condition	Name	Phone	Last Seen
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Allergies: __No __Yes

Allergen	Reaction
_____	_____
_____	_____
_____	_____
_____	_____

Health Screening:

Test	When	Where	Results
Bone Density	_____	_____	_____
Cholesterol	_____	_____	_____
Colonoscopy	_____	_____	_____
Cologuard	_____	_____	_____
Dental Exam	_____	_____	_____
Glucose	_____	_____	_____
PSA/prostate	_____	_____	_____
Eye Exam	_____	_____	_____
Mammogram	_____	_____	_____
Pap Smear	_____	_____	_____

Patient Name: _____

Immunizations:

Type	Most Recent
TDAP	_____
MMR	_____
Pneumonia	_____
Hepatitis A	_____
Hepatitis B	_____
Shingles	_____
Prevnar	_____
Flu	_____

Medical History: (please check any conditions you have been diagnosed with)

__ADHD	__Anemia	__Anxiety
__Arthritis	__Bipolar	__Cancer
__Clotting Issue	__Constipation	__Depression
__Diabetes Type I	__Diabetes Type II	__Epilepsy/Seizures
__Gallstones	__Glaucoma	__Fibrocystic Breast
__Fibromyalgia	__Hearing Issues	__Heart –Artery Disease
__Heart – Murmur	__Heart –Valve	__Herpes – Genital
__High Blood Pressure	__High Cholesterol	__HIV
__Hyperthyroid	__Hypothyroid	__Infertility
__Irritable Bowel	__Kidney Infection	__Kidney Stones
__Mental Illness	__Migraine Headaches	__Ovarian Cyst
__Pneumonia	__Pulmonary Embolism	__Stroke
__Transfusions	__Tuberculosis	__Ulcer
__Urinary Incontinence	__STD	__Vision Problems

Additional Details regarding above AND/OR Problems not listed above:

_____

_____

_____.

Patient Name: _____

Past Surgical History:

Surgery	Surgeon	Date
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Family Medical History:

Mother: _____

Father: _____

Siblings: _____

Maternal Grandmother: _____

Maternal Grandfather: _____

Paternal Grandmother: _____

PaternalGrandfather:_____

Children:_____

Other pertinent Medical History:

_____

_____

_____

_____

Patient Name: _____

Social History:
Marital Status:
__Married __Divorced/Separated __Single __Widow/er

Children: __No __Yes; Ages:_____

Who do you live with?_____

Education: Last Grade completed_____

Occupation: _____ __Full-time __Part-time

Exercise: Type_____ How often_____

Wear Seatbelt: __No __Yes

Tobacco Use: __No __Yes; Type/Frequency_____

How do you Identify? __Male __Female _Other_____

Sexual Activity: Sexually involved currently __No __Yes

Sexual Partner is/are/have been __Male __Female __Both

Drug use:
Any illicit drug use __No __Yes; Type/Frequency_____

Patient Name: _____

Medication List (you can bring your own list)

Name	Dose	Frequency	Start Date	Reason

Pharmacy

Name/Number

Local: _____

Mail Order: _____