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New patient Health Questionnaire

Today's date: _____

Patient Name: _____ AGE: _____ Sex: _____

Briefly state the reason for today's visit?

List medical problems that you have or had in the past:

Onset/date	MEDICAL PROBLEMS	date	SURGERIES

List all current Medications (include Over-the-Counter medications and supplements)

Drug Name	Dosage	Frequency	Prescribing Doctor

Allergies:

No Known Drug Allergies **OR**

Name of Drug allergic to	Type of Reaction

VACCINATIONS

Tdap booster: date _____	Pneumovax: date: _____	Shingles date: _____
Hepatitis: date: _____	Meningococcal date: _____	Other: _____

Name: _____

SOCIAL HISTORY

1. Smoke Cigarettes?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	How much, how long? _____
2. Alcohol Use?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	How much, how long? _____
3. Recreational Drugs?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	What drug, how long? _____
4. Occupation:	_____ Occupational Hazards _____		
5. Current employer:	_____		

FAMILY MEDICAL HISTORY (age, illnesses)

Mother:	_____
Father:	_____
Brothers:	_____
Sisters:	_____
Children:	_____
_____	_____

Health Screening Exams, date and findings

Eye Exam:	_____	Colonoscopy:	_____
Pap smear:	_____	Mammograms:	_____

Review of Systems: Check if you have any of these symptoms

NEUROLOGICAL:

- | | | | |
|--|---------------------------------------|-------------------------------------|--|
| <input type="checkbox"/> Headaches/Migraines | <input type="checkbox"/> Seizures | <input type="checkbox"/> Fainting | <input type="checkbox"/> Numbness/Tingling/Burning |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Stroke / TIA | <input type="checkbox"/> Tremor | <input type="checkbox"/> Head Injury |
| <input type="checkbox"/> Panic Disorder | <input type="checkbox"/> Depression | <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Insomnia |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Other: _____ | | |

Eyes, Ears, Nose Throat:

- | | | | |
|---|---------------------------------------|---|---|
| <input type="checkbox"/> Vision changes | <input type="checkbox"/> Eye Pain | <input type="checkbox"/> Glasses/Contacts | |
| <input type="checkbox"/> Changes in hearing | <input type="checkbox"/> Hearing Aids | <input type="checkbox"/> Ringing in ears | <input type="checkbox"/> Snoring or apnea |
| <input type="checkbox"/> Sinus infections | <input type="checkbox"/> Hay fever | <input type="checkbox"/> Vertigo | <input type="checkbox"/> Hoarseness |
| <input type="checkbox"/> Other: _____ | | | |

CARDIOVASCULAR:

- | | | | |
|--|---|---|---------------------------------------|
| <input type="checkbox"/> Irregular heartbeat | <input type="checkbox"/> Chest Pains | <input type="checkbox"/> Palpitations | <input type="checkbox"/> Heart murmur |
| <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Angina or heart attack | <input type="checkbox"/> Congestive heart failure | <input type="checkbox"/> Pacemaker |
| Other: _____ | | | |

RESPIRATORY:

- | | | | | |
|--|---------------------------------|-----------------------------------|--|--------------------------------|
| <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Asthma | <input type="checkbox"/> Wheezing | <input type="checkbox"/> Coughing up blood | <input type="checkbox"/> Cough |
| <input type="checkbox"/> Other: _____ | | | | |

GASTROINTESTINAL

- | | | | | | |
|---|---------------------------------------|-------------------------------------|---|---------------------------------------|---------------------------------------|
| <input type="checkbox"/> Nausea/ Vomiting | <input type="checkbox"/> Stomach pain | <input type="checkbox"/> Ulcer | <input type="checkbox"/> Diarrhea or constipation | | |
| <input type="checkbox"/> Heartburn | <input type="checkbox"/> Acid Reflux | <input type="checkbox"/> Gallstones | <input type="checkbox"/> Appetite changes | <input type="checkbox"/> Pancreatitis | <input type="checkbox"/> Colon polyps |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Other _____ | | | | |

GENITOURINARY:

- | | | | | |
|---|---|---|--|--------------------------------------|
| <input type="checkbox"/> Frequent urination | <input type="checkbox"/> Urinary Incontinence | <input type="checkbox"/> Blood in urine | <input type="checkbox"/> STD: _____ | |
| <input type="checkbox"/> Prostate issues | <input type="checkbox"/> recurrent UTI's | <input type="checkbox"/> Erectile Dysfunction | <input type="checkbox"/> Kidney stones | <input type="checkbox"/> Other _____ |

Name: _____

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Females:

Last menstrual period: _____ Are periods regular? _____ Birth control method _____

Last PAP Smear _____ Normal ? _____

MUSCULOSKELETAL:

- Joint swelling Joint pain Back pain Muscle pain Muscle cramps
 Arthritis _____

Endocrine

- Diabetes Excessive sweating Heat/Cold intolerance Thyroid disorder Other: _____

Skin

- Rashes Lumps Moles of concern Eczema Psoriasis Rosacea Skin cancer

Cancer & Blood disorders

- Anemia (low blood count) Easy bleeding or bruising Hx blood clots Cancer: _____
 Blood transfusions

General

- Fatigue or change in energy loss of appetite Change in weight _____ Weakness Fever
 Night sweats Excessive hair loss

Do you want us to discuss or disclose your medical issues and billing records to any one ? If so please provide name and relationship:

_____ Relationship: _____

Consent for treatment and release of records: I understand that during the course of treatment my doctor may refer me to other physicians and for effective and timely communication my medical and demographic information may be faxed or mailed or verbally transmitted to the consulting doctor's office to expedite my care. I also authorize this office to fax, mail or email (secure email) my medical information to my insurance company for the purpose of treatment authorization and reimbursement.

I also acknowledge that I have been informed of NO SHOW and Cancellation policy. If appointments are not rescheduled or cancelled with 24 hour notice I will be charged a NO SHOW fee. First violation results in \$50.00 fee, second violation \$75.00 fee and third violation full amount for the scheduled appointment and possible dismissal from care.

Signature: _____ Date: _____

Signature of guardian or parent (if minor) : _____ Doctors initials: _____