

NEW PATIENT QUESTIONNAIRE

Patient: _____ DOB: _____ MR#: _____ Date: _____

Your current medication(s), medication allergies, and past health problems are an important part of your diagnosis and treatment plan. Please try to answer all questions fully.

What problem are you being seen for today? _____

Who referred you to our office? _____

What medications are you currently taking? Include any blood thinning over the counter agents such as aspirin, Motrin, Orudis, Aleve, Relafen, Lodine, ibuprofen, or naproxen. If you have a list, please let us make a copy of your list.)

_____	_____
_____	_____
_____	_____
_____	_____

What medication allergies do you have? Please include the type of reaction you experienced:

Do you smoke? Yes _____ No _____ If yes, how many packs a day? _____ For how many years? _____

Do you chew tobacco? Yes _____ No _____ If yes, for how many years? _____

Do you drink alcohol on a regular basis? Yes _____ No _____ If yes, how many drink/ day or week? _____

Do you use any other "recreational drugs"? Yes _____ No _____

Have you received radiation in the past? Yes _____ No _____

Please list medical problems that are currently being treated by another physician (i.e. Hypertension, Heart Attack, Emphysema, etc.):

_____	_____
_____	_____
_____	_____

Please list any surgeries (and approximate dates if you remember) you have had in the past:

_____	_____
_____	_____

Any adverse reactions to anesthesia? If so, please explain _____

If you are working, what is your occupation? _____

Are you married? Yes _____ No _____ Name of your spouse/partner: _____

Please list any other information you think your physician should know about your health:

Physician Initials _____ Date _____

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The following list reviews a number of health problems. Please place a check mark if you or your family has experienced any of these health problems.

	Problem	Patient	Family	Please explain
General	Fever/chills Fatigue Weight change			
Eye	Change in vision Glasses Cataracts or glaucoma			
Ear, Nose, & Throat	Nosebleeds Sore throat or tonsillitis Hoarseness Swallowing problems Hearing problems Dizziness or Vertigo Sinus or nose problems Tinnitus (ears ringing)			
Allergy	Seasonal Hayfever Food reactions Allergy shots Latex reactions			
Lung	Asthma Chronic cough Bronchitis or pneumonia			
Heart	Chest pain or palpitations Congestive heart failure Heart disease or surgery High blood pressure Coronary artery disease High cholesterol/ triglycerides			
GI	Acid reflux / heartburn Abdominal pain Peptic ulcer disease Hepatitis / jaundice			
GU	Prostate problems GYN problems			
MS	Arthritis problems Back or neck problems Muscle weakness Gout			
Skin	Hives or rashes Eczema Breast disease			
Neurologic	Stroke Seizures Headaches or Migraines Neurologic problems			
Endocrine	Diabetes Thyroid problems Pituitary or adrenal problems Perimenopausal symptoms			
Psyche	Depression Anxiety			
Immune	Bleeding disorders Anemia problems Enlarged lymph nodes HIV / AIDS			

Physician Initials _____ Date _____

