

NEW PATIENT QUESTIONNAIRE

Name: _____ Date of Birth: _____ Gender: Male Female

What is the reason for your visit? _____

What are your main concerns for this visit? _____

Which physician referred you? _____ Physician telephone number: _____

LIST ALL OF YOUR PHYSICIANS:

SPECIALTY:

Do you have any drug allergies (specify name of drug & reaction): _____

MEDICATIONS – Include ALL over-the-counter supplements, herbal meds and vitamins:

Name of Medication	Dose (example: 20 mg)	How Taken (if not oral)	Times taken (example: one pill 3 times per day)
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			
13.			
14.			
15.			
16.			

Have you used or received any steroids in the past 6 months (this includes any topical steroids, joint injections of steroids, oral medications, or inhaled steroids)? Yes No Maybe/don't know

If yes, describe: _____

PAST MEDICAL HISTORY

Do you have (or have you had) any of the following conditions?

	Yes	No		Yes	No		Yes	No
Diabetes			Emphysema or COPD			Arthritis		
High blood pressure			Thyroid problems			Osteoporosis		
High cholesterol			Liver disease			Broken bones		
Vision problems			Anemia			Kidney stones		
Kidney problems			Stomach ulcer			Mumps		
Stroke			Gastrointestinal problems			Head/neck radiation		
Cancer			HIV or AIDS			Seizures		
Asthma			Anxiety or Panic Attacks			Tuberculosis		
Sleep apnea			Depression					

Have you ever had a heart attack? Yes No If yes, when? _____

Have you ever had a stress test? Yes No If yes, most recent & result: _____

Have you ever had a heart catheterization? Yes No If yes, result: _____

Have you ever had problems with fluid retention or been diagnosed with heart failure? Yes No

List any other medical problems, major illnesses, or other reasons you see a doctor: _____

Do you have diabetes? Yes No If No, skip to next section.

Have you ever received a pneumonia vaccine? Yes No If yes, most recent: _____

Do you receive flu shots every year? Yes No

When was your last eye exam? _____

Have you ever been told you had diabetes-related problems with your eyes? Yes No

Have you ever received laser treatment for your eyes? Yes No

Have you ever been told you had problems with your kidneys or required dialysis? Yes No

Have you ever seen a kidney specialist? Yes No

Do you suffer from numbness or tingling in the feet or legs? Yes No

Have you ever had foot ulcers or foot infections? Yes No

Women:

Last menstrual period: _____ Age of 1st menstrual cycle: _____

Number of pregnancies: _____ Number of births: _____

PAST SURGICAL HISTORY

Please list any surgical procedures you've had and the year performed:

_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

FAMILY MEDICAL HISTORY

Relation	Age	Medical Conditions and/or cause of death
Mother		
Father		
Brother		
Sister		
Brother		
Sister		

Has any family member been diagnosed with:

	Yes	No	Relation to patient (example: father, sister, etc.)
Diabetes			
Thyroid disease or thyroid cancer			
Pituitary problem or tumor			
Adrenal problem or tumor			
Osteoporosis or hip fracture			
Kidney stones			
High blood pressure			
High cholesterol			
Heart disease or heart problems			
Stroke			
Cancer			

PERSONAL & SOCIAL HISTORY:

Marital status: Never married Married Widowed Divorced Separated Other

Number of children: ____ Ages: _____

Occupation: _____ Highest level of education you completed: _____

Have you ever used tobacco products? Yes No Quit If quit, when? _____

If yes (or quit), how much (i.e. packs per day)? _____ Approx. years smoking: _____

How many alcoholic beverages do you drink per week on average? _____

Have you ever used recreational drugs? _____

Do you exercise regularly? Y / N If yes, what do you do? _____

REVIEW OF SYSTEMS

Have you recently had problems with any of the following?

	Yes	No		Yes	No		Yes	No
Weight loss			Abdominal pain			Dizziness		
Weight gain			Change in bowels			Numbness or tingling		
Fatigue			Constipation			Seizures		
Change in appetite			Diarrhea			Intolerance to heat		
Fevers			Nausea/vomiting			Intolerance to cold		
Headache			Heartburn/reflux			Excessive thirst		
Blurry vision/eye pain			Urinary difficulties			Changes in hair		
Hearing problems			Frequent urination					
Voice change/hoarseness			Back pain			WOMEN:		
Neck swelling			Joint pain			Changes in periods		
Difficulty swallowing			Broken bones			Decreased sex drive		
Chest pain			Depressed mood					
Palpitations/ heart racing			Anxiety			MEN:		
Leg swelling			Insomnia			Decreased sex drive		
Leg pain with walking			Rash			Pain/lump in testicles		
Cough			Skin changes			Problems with erections		
Shortness of breath			Breast tenderness					
Excessive snoring			Breast discharge					

Other: _____

