QUESTIONNAIRE: NEW PATIENT

Patient Name:	Date of Birth:
What do you prefer to be called:	Who referred you:

Allergies:	Reaction	Notes
Adhesive tape		
Iodine		
Latex Exam Gloves		
PENICILLINS		
SALICYLATES		
SULFA (SULFONAMIDES)		
Other:		

Medication List:

Name	Date Started	Dose
Example: Lipitor 20 mg	12/30/10	Take 2 tabs (40 mg) by oral route once daily for 30 days

Health Maintenance Testing

☐ Mammogram Month_____ Year_____

☐ Bone Density/Dexa Scan Month_____ Year_____

Continued...

QUESTIONNAIRE: NEW PATIENT

Patient Name: Date of Birth:

Family Medical History

Disease Name/Relative/Age	Disease Name/Relative/Age	Disease Name/Relative/Age
☐ Alzheimers's Disease	☐ CVA (Stroke)	☐ Major Depression
☐ Anemia	☐ Coronary Artery Disease	☐ Ovarian Cancer
☐ Asthma	☐ Depression	☐ Schizophrenia
☐ Bipolar Disorder	☐ DM Type 1	☐ Sickle Cell Trait
☐ Breast cancer	☐ DM Type 2	☐ Stroke
☐ Migraine Headaches	☐ Emphysema	☐ Sudden Death
☐ Heart attack/Bypass Surgery	☐ Hypercholesterolemia (High cholesterol)	☐ Throbophlebitis/Blood Clotts
☐ Colon Cancer	☐ Hyperthyroidsim (Hight Thyroid)	☐ Tremor
☐ Congestive Heart Failure	☐ Hypothyroidism (Low Thyroid)	☐ Uterine Cancer
☐ Other: _____		

Notes: _____

Past Medical History

Disease Name	Disease Name	Disease Name
☐ Abdominal Aortic Aneurysm	☐ Migraines	☐ Erectile Dysfunction
☐ Abnormal Electrocardiogram (ECG)	☐ Breast Cancer, Malignant	☐ Lung Cancer
☐ Abnormal Mammogram	☐ Colon cancer	☐ Lymphoma
☐ Abnormal Pap Smear	☐ Chronic Renal Failure	☐ Major Depression
☐ Hair Loss	☐ Hepatitis	☐ Malignant Melanoma Of Skin
☐ Amenorrhea (Absence of Menstruation)	☐ Constipation	☐ Multiple Sclerosis
☐ Anemia	☐ COPD	☐ Obstructive Sleep Apnea
☐ Ankylosing Spondylitis	☐ Coronary Artery Disease	☐ Osteoporosis
☐ Arthritis, Rheumatoid	☐ CVA (Stroke)	☐ Panic Disorder
☐ Asthma	☐ Diabetes Mellitus, Type 1	☐ Pelvic Inflammatory Disease
☐ Atrial Fibrillation	☐ Diabetes Mellitus, Type 2	☐ Pelvic Pain
☐ Atrial Flutter	☐ Diverticulitis	☐ White Blood Cell Disorder
☐ Backache	☐ Breast mass	☐ Skin Cancer
☐ Hypertension (High Blood Pressure)	☐ Emphysema	☐ Systemic Lupus Erythematosus
☐ Bipolar	☐ Ulcer	☐ _____
☐ Bone Infection	☐ Heart Valve Replacement	☐ _____
☐ Von Willebrand's Disease	☐ Traumatic Injury	☐ _____

Problem List (Past Medical History)

Disease Name	Date of Onset	Notes

Continued...

Patient Name: Date of Birth:

Past Surgical History continued...

Procedure Name	Procedure Name	Procedure Name
☐ Abdominal Aortic Aneurysm Repair	☐ Cholecystectomy (Gall Bladder Removal)	☐ Lumbar Disc Surgery
☐ AICD Placement (Pacemaker/Implanted Defibullator)	☐ Ankle Surgery	☐ Coronary Artery Bypass Graft (CABG)
☐ Lumbar Intervertebral Disk Surgery	☐ Aortic Valve Replacement	☐ Foot Surgery
☐ Lumbar Spinal Fusion	☐ Appendectomy	☐ Hand Surgery
☐ Lumpectomy Left Breast	☐ Back Surgery	☐ Heart Transplant
☐ Lumpectomy Right Breast	☐ Hip Replacement Right	☐ Hip Replacement Left
☐ Mastectomy Left Breast	☐ Hysterectomy	☐ Carotid Endarterectomy
☐ Mastectomy Right Breast	☐ Knee Replacement Left	☐ Mitral Valve Replacement
☐ Carpel Tunnel Release	☐ Knee Replacement Right	☐ Nephrectomy (Kidney removal)
☐ Cervical Intervertebral Disk Surgery	☐ Knee Surgery	☐ Shoulder Surgery
☐ Cervical Spine Fusion	☐ Laminectomy	☐ Sinus Surgery
☐ Cervical Spine Surgery	☐ Other_____	☐ Transurethral Resecton of Prostate
☐ Bariatric Surgery		☐ Other_____

Notes: _____

Reproductive Hisotry (if applicable)

Menstrual

Pregnancy Summary

Total Pregnancies:_____ Full Term:_____ Premature:_____

AB Inducted (Abortions):_____ AB Spontaneous (Miscarriages:_____ Ectopic:_____

Multiples (i.e., twins):_____ Living:_____

Social History

Marital Status: ☐ Single ☐ Married ☐ Widowed

Occupation:_____

Alcohol use? ☐ Yes ☐ No How much per day?:_____

Tobacco use? ☐ Yes ☐ No; packs per day ____; year quit ____

Smokeless Tobacco? ☐ Yes ☐ No;

History of IV Drug Abuse? ☐ Yes ☐ No; notes:_____

Any Other Drug Abuse? ☐ Yes ☐ No; what kind:_____

Children? Number and Ages:_____

Do you have a have any history of:

Sexual abuse?_____

Physical abuse?_____

Multiple Sexual Partners?_____

Traveled outside the state in the last 12 months? To what state _____ To what country _____

Continued...

Patient Name: Date of Birth:

Immunizations List

☐ Flu Shot Month/Year _____ Administering Provider: _____

☐ Pneumonia Shot Month/Year _____ Administering Provider: _____

Vaccine	Date	Provider	Vaccine	Date	Provider

Please Indicate Your Preferred Form of Communication

Phone:_____ Fax: _____

Mail:_____

Other:_____

Patient Portal

Declined

For whom do you give us permission to talk to regarding your healthcare services? _____

I have carefully reviewed this questionnaire and completed it to the best of my knowledge.

_____ _____

Signature of patient, parent or legal guardian (circle one) Date / Time