

**New Patient Questionnaire**

Name \_\_\_\_\_ DOB \_\_\_\_\_ Date \_\_\_\_\_

**Medical History** (This refers to medical problems that have already been diagnosed or treated. Please explain how this is treated, such as diet, medication, surgery, etc.)

Condition	When was it diagnosed	Resolved? How was/is it treated?
Abnormal Pap smear		
Alcohol or drug problems		
Alzheimer's/ dementia		
Anemia		
Anxiety disorder		
Asthma		
Blood clot in leg (DVT)		
Blood clot in lung (PE)		
Cancer of breast		
Cancer of colon		
Cancer of prostate		
Cancer of skin, melanoma		
Cancer of skin, other		
Cancer of other		
COPD/ emphysema		
Depression		
Diabetes		
Epilepsy		
Glaucoma		
GERD/ Chronic reflux		
Gout		
Heart attack/ angina		
Herpes		
High blood pressure		
High cholesterol		
HIV/AIDS		
Irritable bowel syndrome		
Hepatitis		
Migraines		
Osteopenia/osteoporosis		
Rheumatoid Arthritis		
Stroke		
Thyroid overactive		
Thyroid underactive		
Other condition		



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## **Prescription medications**

Name of medication	Is it a Capsule or tablet or liquid	Strength	How often is it taken?

## **Family History**

Family Member	If alive, DOB	If deceased, age of death
Mother		
Father		
Siblings		
Children		

Condition	Who had this
Breast cancer	
Colon Cancer	
Other cancer	
Diabetes	
High Blood pressure	
High cholesterol	
Stroke	
Heart attack	
Osteoporosis	
Thyroid over or underactive	
Other inherited conditions	



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**Review of Systems** (Do you have frequently or have you had any of the following in the past month?)

**General:**

- Fever
- Weight loss
- Night sweats
- Trouble sleeping

**Skin:**

- Rash
- Change in mole

**Blood:**

- Easy bruising
- Excessive bleeding

**Endocrine:**

- Cold intolerance.
- Heat intolerance.
- Excessive thirst

**Eye:**

- Vision changes
- Blind spots

**Ears:**

- Ringing
- Decreased hearing

**Nose/Mouth:**

- Dental abscess
- Nosebleeds
- Nasal congestion

**Neck:**

- Goiter
- Chronic pain

**Breasts:**

- Nipple discharge
- Pain

- Lumps

**Cardiovascular:**

- Chest pain
- Shortness of breath

- Leg swelling

- Palpitations
- Exercise intolerance

**Pulmonary:**

- Chronic cough
- Wheezing
- Pain with breathing

**Digestive:**

- Heartburn.
- Constipation.
- Diarrhea
- Abdominal pain.

**Genitourinary:**

- Recent infection

- Urination at night time (#\_\_\_)

- Difficulty with erections

- Blood in urine

**Skeletal:**

- Arthritis.
- Chronic joint pain

**Brain and Nerves:**

- Dizziness.
- Specific weakness
- Memory loss
- Tremor.
- Blackouts, fainting

**Psychiatric:**

- Eating disorder
- History physical abuse

- Anxiety
- Depression

**For Women:**

- Date of last period \_\_\_\_\_
- Irregular periods
- Heavy bleeding
- Painful intercourse

**Health maintenance**

Pneumonia vaccine: Pneumovax \_\_\_\_\_ Prevnar 13 \_\_\_\_\_

Last mammogram \_\_\_\_\_

Last colonoscopy \_\_\_\_\_

Last bone density/ DXA \_\_\_\_\_

Last chest x-ray \_\_\_\_\_

Last Pap smear \_\_\_\_\_

Last tetanus vaccine \_\_\_\_\_

Shingles vaccine \_\_\_\_\_

Childhood vaccines \_\_\_\_\_