NEW PATIENT QUESTIONNAIRE

PLEASE PRINT

Full name:_____Age:_____

Preferred Contact number:_____

Email address:_____

Why are you here today? ☐ To establish or transition care ☐ Annual exam ☐ Consultation from another doctor

If consultation, for what condition_____Referring Physician_____

If you were not referred by another physician, how did you find out about us? ☐ Website ☐ Social Media

☐ Phone Book ☐ Billboard ☐ Newspaper ☐ Name of friend/relative_____

Please list the 2 main health issues you would like to address during your visit today:

1) _____ 2)_____

PLEASE LIST ALL PRESCRIPTION MEDICATIONS & CONTRACEPTIVESTHAT YOU ARE CURRENTLY TAKING

Name	Dosage	Times/day	Treatment for what condition	1st prescribed

PLEASE LIST ALL OVER THE COUNTER MEDICATIONS THAT YOU ARE CURRENTLY TAKING
Including vitamins and herbal medications

Name	Dosage	Times/day	Treatment for what condition	1st prescribed

PHYSICIAN NOTES SECTION - HPI

ALLERGIES

Please list any medications or products you have taken which cause a true allergic reaction (hives, itching, rash, or difficulty breathing):_____

_____

INDICATE ANY OF THE FOLLOWING ILLNESSES YOU NOW HAVE OR HAVE HAD IN THE PAST

CONDITION	YEAR	TESTS PERFORMED	TREATMENT RECEIVED
High blood pressure			
Heart disease			
High cholesterol			
Stroke			
Diabetes mellitus			
Seizures			
Glaucoma			
Osteoarthritis			
Thyroid			
Osteoporosis			
Cancer (if yes, what type)			
Stomach ulcers/reflux disease			
Uterine fibroids			
Urinary incontinence			
Depression			
Panic disorder			
Eating disorder			
Breast biopsies			
Abnormal pap smear			
Other			

SURGERY	YEAR

OB/GYN HISTORY

Date of last menstrual cycle___/___/_____
Number of pregnancies? _____
Number of live births? _____
Method of birth control_____

Was your uterus removed? □ Yes □ No
Why?_____

Have your ovaries been removed? □ Yes □ No
If yes, why?_____

FAMILY HISTORY

List all major illnesses including cancers, heart conditions, diabetes, high blood pressure, high cholesterol, depression, osteoporosis, kidney disease.

Father's History

Is your Father? □ Alive – Age _____ □ Deceased – Age _____

What types of health problems if any did he have?

Mother's History

Is your Mother? □ Alive – Age _____ □ Deceased – Age _____

What types of health problems if any did she have?

Do you have any brothers or sisters?

What types of health problems do/did they have?

Do your children have any health issues?

What types of health problems do/did they have?

SOCIAL HISTORY

Current employment status: □ Disabled □ Part time □ Full time □ Retired □ Self-employed □ Other

What type of occupation do you (or did) you have?

Current marital status? □ Single □ Married □ Separated □ Divorced □ Widowed □ Other

HABITS

Have you ever smoked cigarettes regularly? □ Yes □ No If yes, how many packs per day? (avg)

How many years?_____Are you still smoking? □ Yes □ No If no, when did you stop?_____

Do you drink alcoholic beverages? □ Yes □ No

How many beers day/week?_____ How many mixed drinks or glasses of wine daily?_____

Do you have any drug, nicotine or alcohol habits which concern you? □ Yes □ No

Do you exercise? □ Yes □ No Type _____

Days per week exercise performed_____ Minutes per session_____

LIST A DAY OF YOUR USUAL DIET

Breakfast	Lunch	Dinner	Snacks (what hour)

SEXUAL HEALTH

Are you sexually active? □ Yes □ No
If yes, are you satisfied with your current sexual experiences? □ Yes □ No
If no, what portion are you not satisfied with? □ Sex drive □ Orgasm □ Arousal □ Lubrication
Do you experience pain with intercourse? □ Yes □ No
Does your partner have any sexual difficulties? □ Yes □ No

Other?_____

Sexual health scale (0 not good 10 excellent)

0 1 2 3 4 5 6 7 8 9 10

MENTAL AND EMOTIONAL HEALTH

Do you feel emotionally balanced? □ Yes □ No

What are your primary sources of stress?_____

Who is your biggest support group in times of stress? □ Immediate family □ Friends □ Spouse

Emotional health scale (0 not good 10 excellent)

0 1 2 3 4 5 6 7 8 9 10

SOCIAL HEALTH

Do you have questions or concerns about Advanced Directives or a Living Will? □ Yes □ No

If yes, please describe:_____

Please list which documents you currently have:_____

HEALTH MAINTENANCE

When was your last mammogram_____ Location performed_____

Was a breast procedure performed_____

When was your last pap smear_____ Location performed_____

Was a biopsy or other procedure was performed:_____

When was your last bone densitometry_____ Location performed_____

What was the result_____

When was your last colonoscopy_____ Performing doctor_____

Were colon polyps ever found_____

IMMUNIZATIONS

TYPE	YEAR	TYPE	YEAR
Tetanus booster		Tetanus, diphtheria	
Tetanus, diphtheria, (Tdap)		Pneumonia vaccine	
Flu vaccine		Hepatitis B	
HPV vaccine		Shingles vaccine	
Eye exam		Do you wear a seat belt?	□ Yes □ No □Sometimes

REVIEW OF SYSTEMS

Please check any of the following symptoms or problems you are currently experience on a regular basis. If the problem has been resolved, leave it blank. If you are unsure, place a question mark (?) by the medical issue.

General
- □ Changes in weight
- □ Fatigue
- □ Trouble getting to sleep
- □ Trouble staying asleep
- □ Any issues affecting quality of sleep

Eyes
- □ Changes in vision

Nose/Throat
- □ Earaches
- □ Hearing problems
- □ Frequent sinus problems

Respiratory
- □ Wheezing
- □ Shortness of breath

Skin
- □ Rash
- □ Excess facial hair/body hair
- □ Changes in moles

Hematological
- □ Frequent bruising
- □ Bleed easily

Breast
- □ New or unusual lumps
- □ Nipple discharge

Urogenital
- □ Incontinence
- □ Vaginal Dryness
- □ Pelvic Pain

Cardiovascular
- □ Chest pain or pressure
- □ Swelling of legs
- □ Rapid heartbeat

Musculoskeletal
- □ Muscle weakness
- □ Muscle or joint pain
- □ Joint swelling

Gastrointestinal
- □ Frequent diarrhea
- □ Nausea/Vomiting
- □ Constipation
- □ Heartburn

Neurological
- □ Dizziness or trouble walking
- □ Numbness
- □ Memory problems
- □ Frequent or severe headaches

Psychiatric
- □ Depression
- □ Anxiety

Endocrine
- □ Hair loss
- □ Excessive thirst
- □ Cold intolerance
- □ Hot flashes

We appreciate your cooperation in completing this form for your physician.