Acct # _____

New Patient Questionnaire

Name: _____DOB:____/____/_____Todays Date:____/____/_____

Who is your Primary Care Physician? _____

Who referred you to us?_____

Please list any medications you are taking, including over the counter medications (use backside it needed):

Medication	**Dose**	**How often?** (3 times/day, night, etc.)

Do you have any allergies to Medications? **N** **Y** If yes, please explain_____

_____

List any other medical conditions: _____

_____

_____

Please list any prior surgeries: _____

_____

_____

Social History:

Do you smoke? **N** **Y** If yes, How many?_____How often?_____ How many years?_____

Do you drink alcohol? **N** **Y** If yes # of drinks a week?_____

Review of Systems:

Please CIRCLE symptoms you are ***currently*** experiencing or experienced in the last Month :

Change of appetite
Chills
Night Sweats
Fatigue
Voice Problems
Sore Throat
Blood Clot in Lungs
Chest Pain
Difficulty Breathing
Shortness of Breath
Breast – Nipple Discharge
Breast Lump

Abdominal Pain
Heartburn/Acid Reflex
Blood in Stools
Jaundice/Yellow of the Skin
Constipation
Diarrhea
Rectal Bleeding
Nausea
History of BPH
Difficulty Urinating
Lower Back Pain
Painful Joints

Pain/Cramping with Exertion
Ulceration of Feet
Lumps/Bumps on Skin
Easy Scarring/Ketoids
Skin Cancer
History of Strokes
History of Seizures
History of Mini-Strokes (TIA)
Anxiety
Depressed Mood
Eating Disorders
Other: _____

If needed, please explain symptoms and how often (use backside if needed):

_____

_____

_____