NEW PATIENT QUESTIONNAIRE

Today's Date: _____ **Referring Physician**:_____

Patient Name: _____
Last First Middle

Date of birth: _____ Age: _____ Sex:_____ Height:_____ Weight:_____

Chief complaint: _____

Describe your problems:

ALLERGIES (Circle all***)***: Penicillin or other antibiotics / Sulfa Drugs / Local Anesthetic / Latex / Iodine / Aspirin / Metal

Any other medications please list: _____

If yes, explain reaction: _____

MEDICATIONS: List ALL medications and doses that you currently take.

Medications	Doses	Medications	Doses

MEDICAL HISTORY and FAMILY HISTORY:

	You	Family		**You**	Family
Heart disease			Wound healing problems		
High blood pressure			Psychiatric problems		
Diabetes			Weight loss/gain		
Asthma/Emphysema			Ears/Nose/Mouth/Throat		
Cancer			Gum disease/Tooth abscess		
Stroke			Prostate problems		
Gout			Urine incontinence		
Pseudogout			Hepatitis, HIV		
Rheumatoid arthritis			Tuberculosis		
Gallbladder disease			Stomach ulcer		
Kidney disease			Acid reflex		
Seizure			Skin problems		
Neurological disorder			Bleeding problems		
BLOOD CLOTS			PULMONARY EMBOLISM		

Other and Explain yes to any above: _____

Please See the other side

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SURGICAL HISTORY List ALL ***previous surgeries and year*** surgery took place

1.
2.
3.
4.
5.

SOCIAL HISTORY:

Occupation: _____

Martial status: Single _____ Married _____ Divorced _____ Widowed _____

Living: One story house _____ Two story house _____

Tobacco: No _____ Yes _____ If yes, how many years _____

Alcohol: No _____ Yes_____ If yes, how much a day _____

REVIEW OF SYSTEMS: Circle all that apply.

HEIGHT: _____ WEIGHT: _____

General: Weight loss / gain, fever, chills, night sweats

Eyes: Pain, discharge, redness, glasses / contacts, double vision

HEENT: Sore throat, nasal discharge, hoarseness, ringing in ear, hard of hearing, hearing aids, dentures

Respiratory: Wheezing, cough, shortness of breath, sputum, coughing blood

Cardiovascular: Chest pain, diaphoresis, fainting, foot swelling, palpitations, heart surgery

Gastrointestinal: Acid reflux, gastric ulcer, peptic ulcer, diverticulitis, irritable bowel, diarrhea constipation, bleeding

Neurological: Headache, confusion, memory loss, slurred speech, dizziness, seizures, numbness, tingling

Musculoskeletal: Joint swelling / pain / redness, muscle weakness, walker / cane, limp Breast Abscess, discharge, cancer

Endocrine: Menstrual irregularity, excessive sweating / thirst / hot / cold

Hematologic: Sickle cell, sickle cell trait, hemophilia, anemia, varicose veins, blood clots, pulmonary embolism

Allergies: Hay fever, sinus, food allergies, drug allergies, metal sensitivity, immunosuppressive, autoimmune disease

Skin: Rashes, boils, itching

Psychiatric: Anxiety, depression

History of MRSA or chronic infection: **Yes** **No** If yes, please explain_____

Patient's signature: _____ **Date**: _____

Guarantor Signature (If other than patient): _____ **Date**: _____

Please See the other side