

New Patient Medical History Questionnaire

Name: _____ **Date of Birth:** _____ **Age:** _____ **Date:** _____

Reason for today's visit:

If applicable where is the issue located?

How long has it been happening?

Describe any factors that change the problem, symptom, or illness?

Please list all current prescription medications and over the counter medications:

Medication	Dosage	When taken	Who wrote the prescription	Reason for taking medication
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

Please circle any of the following that pertains to your past medical history:

- | | | | | |
|-----------------|--------------|----------------|------------------|----------------|
| Blood Clots | Head Injury | Drug Addiction | Gallstones | Memory Trouble |
| Hearing Trouble | Heart Murmur | Depression | Mental Illness | Seizures |
| Alcoholism | Diabetes | Hypertension | High Cholesterol | Other: |

Please list any allergies and the corresponding reactions:

Medications: _____ Reaction _____

Environmental: _____ Reaction _____

Food: _____ Reaction _____

Chemical: _____ Reaction _____

Please list any operations you have had and the year you had it:

Have you ever received a blood transfusion? Yes No

Please list why and when for any time you have been hospitalized overnight:

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Please indicate all known health conditions that apply to you and members of your immediate family, including parents, grandparents, siblings, and children:

	Me	Age of Onset/Type	Family Member(s)	Age of Onset/Type
Alcoholism				
Alzheimer's Disease				
Arthritis				
Asthma/Allergies				
Blood Clots				
Blood Disorder(s)				
Cancer:				
Breast				
Colon				
Lung				
Prostate				
Other				
Depression/Anxiety				
Diabetes				
Drug Addiction				
Epilepsy/Seizures				
Emphysema/COPD				
Eye Conditions				
Heart Disease				
High Blood Pressure				
High Cholesterol				
Kidney Disease				
Leg Cramps				
Lung Disease				
Obesity				
Osteoporosis				
Psychiatric Disorder				
Smoking				
Stroke				
Thyroid Disorder				
Tuberculosis				
Ulcer				
Other				

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Please list the current status of your immediate family:

	Please Circle	Age (Now or at Death)	Comments/Cause of Death
Mother	Alive/Deceased		
Father	Alive/Deceased		
Maternal Grandma	Alive/Deceased		
Maternal Grandfather	Alive/Deceased		
Paternal Grandma	Alive/Deceased		
Paternal Grandfather	Alive/Deceased		
Sibling 1	Alive/Deceased		
Sibling 2	Alive/Deceased		
Sibling 3	Alive/Deceased		
Sibling 4	Alive/Deceased		

Do you use a smoke detector? Yes No

Do you exercise? Yes No _____ Times a week

What is your highest level of education completed?

Are you? Single Married Divorced Widowed

Who do you live with?

Do you have pets? Yes No If yes, what type?

What is your occupation?

Do you drink caffeine? Yes No _____ How many cups a day? (i.e., coffee, energy drinks, etc.)

Have you ever used recreational drugs such as marijuana, cocaine, heroin, amphetamines, etc.? Yes No

If yes, what type? _____ How often? _____ Year you quit? _____

Do you smoke cigarettes? Yes No _____ How many packs a day? _____ Year you quit? _____

Do you chew tobacco? Yes No _____ How much? _____ Year you quit? _____

Do you drink alcohol? Yes No _____ How many drinks a week?

Have you ever had a problem with alcohol on the past? Yes No _____ Year you quit? _____

Have you ever been a victim of emotional, physical, or sexual abuse as a child or adult? Yes No

Are you sexually active? Yes No

When was your last Tetanus shot?

Have you had your HPV immunization?

When was your last Pneumonia immunization?

Have you had your Shingles immunization?

Have you had your Hepatitis B immunization?

When was your last eye exam?

When was your last colonoscopy?

Women Only:

When was your last pap?

When was your last mammogram?

Men Only:

When was your last PSA test?

Signature

Date