

New Patient Questionnaire

Name:	Age:	Marital Status:	S	M
		D		W

Employer:	Position:
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Reason for Visit

PREVENTIVE HEALTH

	Date of last:		Date of last:		Date of last:		Date of last:
Colonoscopy		Gardasil		Flu Vaccine		Tetanus	
Pap Test		Mammogram		Rubella		Bone Density	

Was last pap: Normal Abnormal Any previous abnormal Pap date _____ Treatment _____

PAST MEDICAL HISTORY: *please check (X) ALL areas that apply to you.*

Vaginal Infections - History of : Yeast Trichomonas Chlamydia Herpes Gonorrhea

<input type="checkbox"/> Arthritis <input type="checkbox"/> Asthma <input type="checkbox"/> Anemia / blood disorder <input type="checkbox"/> Bowel disorders <input type="checkbox"/> Diabetes <input type="checkbox"/> Hepatitis <input type="checkbox"/> Heart disease	<input type="checkbox"/> High blood pressure <input type="checkbox"/> Kidney/bladder problems <input type="checkbox"/> Mitral valve prolapse <input type="checkbox"/> Phlebitis <input type="checkbox"/> Seizures/epilepsy <input type="checkbox"/> Serious injuries	<input type="checkbox"/> Severe headaches <input type="checkbox"/> Skin disease <input type="checkbox"/> Stomach problems <input type="checkbox"/> Thyroid disease <input type="checkbox"/> Urinary incontinence <input type="checkbox"/> Other
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HOSPITAL ADMISSIONS or SURGERIES (excluding pregnancy)

Year	Description	Year	Description

Medication	Frequency of Dose	Medication	Frequency of Dose

DRUG ALLERGIES	REACTION	DRUG ALLERGIES	REACTION

FAMILY HISTORY: *Have any of your close relatives had any of the following conditions?*

Condition:	Relation to you	Maternal/Paternal	Diag. Age	Condition:	Relation to you	Maternal/Paternal	Diag. Age
<input type="checkbox"/> Blood disorder				<input type="checkbox"/> High blood pressure			
<input type="checkbox"/> Breast cancer				<input type="checkbox"/> Kidney disease			
<input type="checkbox"/> Cancer				<input type="checkbox"/> Lung disease			
<input type="checkbox"/> Diabetes				<input type="checkbox"/> Ovarian cancer			
<input type="checkbox"/> Heart attack				<input type="checkbox"/> Stroke			

*In order to provide the highest quality care possible, please complete this form entirely on the front and the back.
Thank you.*

SOCIAL HISTORYSmoking Yes No (# cigs. Per day? _____) Alcohol Yes No _____ Drinks/Week Street drug Yes No

Caffeine Tea/Coffee _____ cups/day Colas _____ cans/day

Exercise: None _____ times per week Activity: _____Sexual History: Satisfactory Uncomfortable Wish to discuss**MENSTRUAL HISTORY**

Age at 1st period _____ Date of last period (1st day) _____ Period Interval (1st day to 1st day) # of days _____

Cramps Yes No Mild Moderate Severe Medication for cramps _____Duration of bleeding _____ Menopausal Yes, I am Pre Post or No I have had a hysterectomy**Contraceptive History** Current Method: _____

Past methods: _____

OBSTETRICAL HISTORY

Total Preg: _____ Full Term Births _____ Premature Births _____ No. of Abortions Induced _____

No. of Abortions: Spontaneous _____ Ectopic Births _____ Multiple Births (twins) _____ Living Children _____

Month / Day / Year	Weeks Preg.	Weight	Sex	Type of Delivery	Remarks
1)					
2)					
3)					
4)					
5)					
6)					

*PLEASE CHECK (X) IF ANY OF THE FOLLOWING SYMPTOMS APPLY TO YOU CURRENTLY***CONSTITUTIONAL**

- Weight loss
- Weight gain
- Fever
- Fatigue

EYES

- Double vision
- Spots before eyes
- Vision changes

EARS, NOSE, THROAT

- Ear aches
- Ringing in ears
- Sinus problems
- Sore throat
- Mouth sores
- Dental problems

BREASTS

- Pain in breast
- Discharge
- Masses
- Implants

CARDIOVASCULAR

- Painful breathing
- Chest pain
- Difficult breathing on exertion
- Swelling of legs
- Palpitations of heart

RESPIRATORY

- Wheezing
- Spitting up blood
- Shortness of breath
- Cough, chronic

GASTROINTESTINAL

- Frequent diarrhea
- Bloody stool
- Nausea/vomiting
- Constipation

GENITOURINARY

- Blood in urine
- Pain with urination
- Urgency
- Frequency of urination
- Incomplete emptying
- Stress incontinence
- Abnormal periods
- Painful intercourse

SKIN

- Rash
- Ulcers

NEUROLOGIC

- Dizziness
- Seizures
- Numbness
- Trouble walking

MUSCULOSKELETAL

- Muscle weakness

ENDOCRINE

- Dry skin
- Abnormal thirst
- Hot flashes

PSYCHIATRIC

- Depression
- Frequent crying

HEMATOLOGIC/LYMPHATIC

- Easy bruising
- Enlarged lymph nodes
- Easy bleeding