New Patient Medical History Questionnaire

Patient Name:____________________________ **DOB**:__________ **Appointment date**:__________

Please answer the following questions:

1. What is your main reason for seeing us today?____

2. Who was your previous primary care physician?____

3. (*Women only*) When was your last menstrual period?____________________________________

Are you currently experiencing any of the following? Check Yes or No

Allergy/Immunology

❑Yes ❑No Anaphylactic Reaction
❑Yes ❑No Swelling
❑Yes ❑No Drug allergy
❑Yes ❑No Food allergy
❑Yes ❑No Latex Allergy

Cardiovascular

❑Yes ❑No Irregular Heart Beat
❑Yes ❑No Chest Pain/Pressure
❑Yes ❑No Dyspnea
❑Yes ❑No Edema
❑Yes ❑No Exercise Intolerance

Constitutional

❑Yes ❑No Fatigue
❑Yes ❑No Fever
❑Yes ❑No Night Sweats
❑Yes ❑No Weight Gain
❑Yes ❑No Weight Loss

Dermatological

❑Yes ❑No Skin Infection
❑Yes ❑No Cyst
❑Yes ❑No Hair Infection
❑Yes ❑No Herpes Simplex

Ear/Nose/Throat/Back

❑Yes ❑No Dizziness
❑Yes ❑No Ear Discomfort
❑Yes ❑No Reflux
❑Yes ❑No Headache
❑Yes ❑No Hoarseness

Endocrine

❑Yes ❑No Chills
❑Yes ❑No Hot Flashes

Eyes

❑Yes ❑No Eyeglasses/contacts
❑Yes ❑No Visual disturbance

Gastrointestinal

❑Yes ❑No Abdominal Pain
❑Yes ❑No Bloody Stool
❑Yes ❑No Constipation
❑Yes ❑No Diarrhea
❑Yes ❑No Gas & Bloating
❑Yes ❑No Nausea
❑Yes ❑No Vomiting

Genitourinary/Nephrology
(male patients: leave women's health questions blank)

❑Yes ❑No Breast Complaint
❑Yes ❑No Painful Urination
❑Yes ❑No Genital Lesion
❑Yes ❑No Bloody Urine
❑Yes ❑No Hypertensions
❑Yes ❑No Menopausal Symptoms
❑Yes ❑No Menstrual Irregularity
❑Yes ❑No Urinate Frequently at Night
❑Yes ❑No Pap Smear Abnormality
❑Yes ❑No Pelvic Pain
❑Yes ❑No Pregnancy
❑Yes ❑No Urinary Frequency
❑Yes ❑No Loss of Bladder Control
❑Yes ❑No Urinary Urgency
❑Yes ❑No Vaginal Discharge

Hematologic/Lymphatic

❑Yes ❑No Abnormal Bleeding/Bruising
❑Yes ❑No Anemia

Musculoskeletal

❑Yes ❑No Back Pain
❑Yes ❑No Muscle Weakness
❑Yes ❑No Osteoporosis
❑Yes ❑No Shoulder Pain
❑Yes ❑No Stiffness

Neurologic

❑Yes ❑No Fainting
❑Yes ❑No Dizziness
❑Yes ❑No Difficulty Walking
❑Yes ❑No Memory Loss

Psychiatric

❑Yes ❑No Anxiety
❑Yes ❑No Depression
❑Yes ❑No Suicidal thoughts
❑Yes ❑No Emotional Issues
❑Yes ❑No Hallucinations

Respiratory

❑Yes ❑No Asthma
❑Yes ❑No Shortness of Breath
❑Yes ❑No Wheezing
❑Yes ❑No Smoker
❑Yes ❑No Cough

Patient Name:_____________________________ **Appointment date**:____________

Medical History

Check the condition(s) that apply to your past medical history:

Cardiovascular

___ Congestive Heart Failure
___ High Blood Pressure
___ Angina
___ Arrhythmia
___ High Cholesterol
___ Blood Clots
___ Heart Attack
___ Peripheral Vascular Disease

Hematological

___ Anemia
___ Blood Clots
___ Bleeding Disorders

Neurological

___ Seizures
___ Peripheral Nerve Disorder
___ Headaches
___ Parkinson's Disease
___ Tremors
___ Stroke
___ Stroke
___ Down Syndrome

Psychiatric

___ Bipolar Disorder
___ Depression
___ Anxiety
___ Personality Disorder
___ Schizophrenia
___ Dementia
___ Substance Abuse
___ Autism

Pulmonary

___ Pulmonary Embolism
___ Pneumonia
___ COPD
___ Asthma
___ Sleep Apnea

Infectious Disease

___ Hepatitis A, B, or C
___ HIV/AIDS
___ Tuberculosis

Oncology

___ Cancer

Gastrointestinal

___ Liver Disease
___ Irritable Bowel Syndrome
___ Heartburn
___ Gastric Reflux
___ Ulcer

Musculoskeletal

___ Osteoporosis
___ Arthritis
___ Back Problems
___ Fibromyalgia
___ Rheumatoid Arthritis

Endocrine

___ Diabetes Type 1
___ Diabetes Type 2
___ Thyroid (Hypo or Hyper)

Surgical History

List any surgeries you have had and when they were preformed:

1.____ 3.____

2.____ 4.____

Social History

Profession/Occupation:____

Smoking Status: Current Past Never Packs per day:_______

Alcohol Use: Current Past Never Drinks per day:_______

Illicit Drug Use: Current Past Never Type:____________________________________

Patient Name:___________________________ **Appointment date**:___________

Family History
Check all that apply **and state the family member relationship**:

Cardiovascular
___ Congestive Heart Failure
___ High Blood Pressure
___ Angina
___ Arrhythmia
___ High Cholesterol
___ Blood Clots
___ Heart Attack
___ Peripheral Vascular Disease

Hematological
___ Anemia
___ Blood Clots
___ Bleeding Disorders

Neurological
___ Seizures
___ Peripheral Nerve Disorder
___ Headaches
___ Parkinson's Disease
___ Tremors
___ Stroke
___ Stroke
___ Down Syndrome

Psychiatric
___ Bipolar Disorder
___ Depression
___ Anxiety
___ Personality Disorder
___ Schizophrenia
___ Dementia
___ Substance Abuse
___ Autism

Pulmonary
___ Pulmonary Embolism
___ Pneumonia
___ COPD
___ Asthma
___ Sleep Apnea

Infectious Disease
___ Hepatitis A, B, or C
___ HIV/AIDS
___ Tuberculosis

Oncology
___ Cancer

Gastrointestinal
___ Liver Disease
___ Irritable Bowel Syndrome
___ Heartburn
___ Gastric Reflux
___ Ulcer

Musculoskeletal
___ Osteoporosis
___ Arthritis
___ Back Problems
___ Fibromyalgia
___ Rheumatoid Arthritis

Endocrine
___ Diabetes Type 1
___ Diabetes Type 2
___ Thyroid (Hypo or Hyper)

OTHER:____

____

____

Patient Name:___________________________ **Appointment date**:___________

Preferred Lab Facility:____

Preferred Pharmacy:____

Current Medications:

Medication Name	Strength	How often do you take?

Over the counter medications

Medication Name	Strength	How often do you take?