

New Patient Questionnaire

(Please complete front and back)

Patient Name: _____ Date: _____

Primary Care Physician: _____

Did a Physician refer you? Yes No If "yes:" Referring Physician: _____

If referral is other than a physician, please indicate: Friend Family Phonebook Internet Other _____

What is the reason for today's visit? _____

When did this problem start? _____ Where is the problem/pain located? _____

What makes the problem/pain worse? _____

What makes it better? _____

What is the severity of this problem (circle one) [minor] 1 2 3 4 5 [severe]

What prior treatment have you received for this problem? _____

List all current medicines: _____

Do you use any of the following? Aspirin Motrin/ibuprofen Plavix Coumadin Vitamin E

What medications are you allergic to? _____

Your Medical History (circle all that apply)

High Blood Pressure	Heart Attack/Angina	Arrhythmia/ Murmur	Diabetes	Stroke
Allergic Rhinitis	COPD(lung disease)	Reflux (GERD)	Migraines	Asthma
Anesthesia Problems	HIV/AIDS/Hepatitis	Kidney Disease	Cancer/Skin Cancer	

Other medical problems not listed: _____

Social History:

Smoking: Never Cigarettes per day: ____ When did you start? ____ When did you quit? ____

Alcohol : Never Occasional Daily

Occupational/Environmental History:

Job Description: _____ Hobbies: _____

Does anyone in your Family have a history of:

Bleeding Disorders	Hearing Loss	High Blood Pressure	Heart Disease
Allergic Rhinitis	Asthma	Cancer	Migraines

(over please)

Major Surgeries and Hospitalizations: (please list date, type of surgery, and reason)

Review of Systems (please circle all that apply)

- | | | | | | |
|-------------------|----------------------|---------------------------|--------------------|--------------------|-------------|
| Constitutional: | fever | weight loss | chills | night sweats | |
| Eyes: | pain | pressure | double vision | glaucoma | cataracts |
| Ears: | pain | tinnitus(ringing) | blockage | hole in eardrum | firearm use |
| | noise exposure | hearing loss | imbalance | vertigo(spinning) | |
| Nose: | hayfever | cat allergy | lawnmowing allergy | | |
| | trauma | stuffy nose | Runny nose | Sinus Infections | |
| Throat: | tonsillitis | throat pain | hoarseness | swallowing trouble | |
| Cardiac: | Irregular beats | Murmur | chest pain | swollen ankles | |
| Respiratory: | shortness of breath | Cough (daytime/nighttime) | | | |
| Gastrointestinal: | Nausea | Constipation | Diarrhea | Blood in stool | |
| Musculoskeletal: | TMJ problems | low back pain | neck arthritis | joint surgery | |
| Skin: | Rash | unusual moles | | | |
| Neurology: | seizures | strokes | chronic headaches | | |
| Lymph: | enlarged lymph nodes | | | | |

Check here if all are negative

Please list any other problems or concerns you think the physician should be aware of:

Patient/Guardian Signature: _____

Physician Signature: _____
