

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 performed:

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:**

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- Congestive Heart Failure
- High Blood Pressure
- Angina
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Hematological

- Anemia
- Blood Clots
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- Schizophrenia
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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?