New Patient Questionnaire

Name:_____Appointment Date:_____

Birthdate:_____Current Age:_____

Please mark any illness or disease you have had in the past or currently have:

_____ Diabetes(sugar)	_____ Kidney Disease	_____ Depression
_____ High Cholesterol	_____ Bladder Problems	_____ Anxiety
_____ Thyroid Disease	_____ Prostate Problems	_____ Psychiatric
_____ High Blood Pressure	_____ Asthma	_____ Arthritis
_____ Heart Attack	_____ Chronic Bronchitis	_____ Osteoporosis
_____ Angina/Chest Pain	_____ Emphysema	_____ Gout
_____ Congestive Heart Failure	_____ Allergies	_____ Back Problems
_____ Other Heart Disease	_____ Pneumonia	_____ Eye Problems
_____ Other Lung Disease	_____ Ear Problems	_____ Hiatal Hernia
_____ Bleeding/Clotting Disorder	_____ Stroke	_____ Liver Disease
_____ Seizures/Epilepsy	_____ Stomach Ulcers	_____ Anemia
_____ Disease of the Colon	_____ Hemorrhoids	_____ Head Injury
_____ Accidents/Broken Bones	_____ Cancer_____	_____ Other _____

Please list any operations or surgeries you have had along with the date and reason.

_____ _____
_____ _____
_____ _____
_____ _____

Do you have any allergies to medication, food, latex or environmental stimuli? What happens?

_____ _____
_____ _____
_____ _____

Please list your current medications including any over the counter medications, vitamins, or herbal remedies you take regularly. Please include the dose if you know it.

_____ _____
_____ _____
_____ _____
_____ _____

Please list any other doctors you see and their specialty.

_____ _____
_____ _____
_____ _____

Do you smoke or chew tobacco? If so, how much, and for how long.

_____

Do you drink alcohol? If so, how much, and how often do you drink.

_____