NEW PATIENT QUESTIONNAIRE

NAME: _____ DOB: _____ DATE: _____

Current Medications:

Please list name and dose of your prescriptions, over-the counter meds, vitamins and supplements:

_____

_____

_____

Medication Allergies (including type of reaction) :_____

_____

Please provide most recent date for the following:

Mammogram: _____

Pap smear: _____

DEXA/Bone density: _____

LMP: _____

Colonoscopy: _____

Pneumonia vaccine: _____

Tetanus: _____

Shingles vaccine: _____

Medical History

Please circle the appropriate items for current/previous conditions as they apply to YOU:

Allergies
Depression
Heart Attack
Anemia
Diabetes
Nerve/muscle disease
Anxiety
Thyroid disease
Ulcers
COPD
Osteoporosis
Arthritis
Reflux/Heartburn/GERD
High Blood Pressure
Heart Failure (CHF)
Kidney disease
Tuberculosis
Clotting disorder
Emphysema
Cataracts
Other: _____

Surgical History:

Please circle the appropriate items for current/previous surgeries as they apply to YOU:

Appendectomy
Cosmetic surgery
Joint replacement
Brain surgery
C-Section
Small intestine surgery
Breast Surgery
Eye surgery/Cataracts
Spine surgery
Gall Bladder Surgery
Fracture surgery
Tubal Ligation
Colon surgery
Hernia repair
Heart Valve Replacement
Heart Bypass
Prostate SurgeryVasectomy
Other: _____

Family History:

Heart Disease: _____

Diabetes: _____

Cancer/Type: _____

Social History:

Occupation:_____

Marital status: Married/Single/Divorced/Widowed Number of children:_____

Alcohol Use: No ___ Yes___ Number of drinks per week:____ Type of alcohol:_____

Drug Use: No ___ Yes___ Past___ Frequency:_____ Type:_____

Tobacco Use: No___ Yes___ Past ___ Quit date: _____ Packs per day_____

Number of years smoked: _____

Smokeless Tobacco Use: No ___ Yes____ Frequency:_____ Type:_____

Sexually Active: No ___ Yes ___ Not currently ____

BEHAVIORAL RISK FACTORS

PHYSICAL ACTIVITY

How many days a week do you usually exercise? _____ days per week.

On days when you exercise, for how long do you usually exercise? _____ minutes per day

How intense is your typical exercise? (Check one)

___ Light (like stretching or slow walking)

___Moderate (like brisk walking)

___I am currently not exercising

___Heavy (like jogging or swimming)

___Very heavy (like fast running or stair climbing)

NUTRITION

On a typical day, how many servings of fruits and/or vegetables do you eat? ___ servings

On a typical day, how many servings of high fiber or whole grain foods do you eat? ___servings

On a typical day, how many servings of fried or high-fat foods do you eat? ___servings

DEPRESSION

Depression Screening	**Not at all**	**Several days**	**More than half the days**	**Nearly all the days**
Over the past 2 weeks, how often have you felt little interest or pleasure in doing things?				
Over the past 2 weeks, how often have you felt down, depressed, or hopeless?				

Please circle any symptoms you are currently having or have recently experienced:

Fevers
Night Sweats
Unexplained Weight Loss
Unexplained Weight Gain
Fatigue
Headaches
Vision Problems
Hearing Problems
Dizziness
Ringing in Ears
Eye Pain
Ear pain
Nosebleeds
Sore Throat
Difficulty Swallowing
Difficulty Sleeping
Persistent Cough

Lightheadedness
Change in Appetite
Abdominal Pain
Nausea
Vomiting
Diarrhea
Rectal pain
Change in Bowel Habits
Blood in Stool
Black Stool
Muscle, Bone, or Joint Pain
Leg Cramps
Skin or Mole Changes
Numbness of Extremities
Muscle Weakness
Tremors
Palpitations/Rapid Heart Beat

Swelling of Extremities
Shortness of Breath
Urinary Problems
Blood in Urine
Frequent Urination
Incontinence
Sexual Dysfunction
Mood Change
Depression/Anxiety
Hoarse Voice
Coughing up Blood
Chest Pain