NEW PATIENT MEDICAL HISTORY QUESTIONAIRE

Today's Date: ______________

Complete the following questionnaire prior to your appointment with the physician. This information is very important to us for your care, so please answer all the section as accurately as possible.

Name: ______________________ **Date of Birth:** __________ **Age:** ______ **Race:** ______

Current Problem (Breifly state why you are here to see the doctor): ______________________

____

Please list your physicians

Surgeon: ______________________ Eye Doctor: ______________________

Previous Physician: ______________________ OB / GYN: ______________________

Preferred Pharmacy: ______________________ Dentist: ______________________

Past Medical History

Condition / Disease	**Yes**	**No**	**Year**	**Condition / Disease**	**Yes**	**No**	**Year**
Alcoholism				Hear Disease			
Anemia				Heart Attack (MI)			
Arthritis				Hepatitis / Jaundice / Liver / Cirrhosis			
Asthma / COPD				High Blood Pressure			
Bleeding / Blood Disorders / Clots				HIV / AIDS			
Bone or Spine				Lung Disease			
Cancer				Prostate Disease			
Cataracts				Seizure / Epilepsy			
Crohn's Disease / Colitis				Stroke			
Diabetes				Stomach Ulcer / Reflux			
Gallbladder Disease / Stones				Tuberculosis			
Glaucoma				Thyroid Disease			

Other significant illness for which you have taken mediation and / or seen a physician for: ______________

____

<u>Female Patients ONLY</u>: Obstetrical and Gynecological History

Age when started periods ______________________ Date of last period ______________________

Last Pap Smear exam __________

Number of pregnancies __________ Number of Live Births __________ Miscarriage / Abortions __________

Have you gone through menopause? __________ What age? ______

Have you had a Hysterectomy? __________ Ovaries removed? __________

Do you do self breast exams? __________ How often? __________

Have you had a mammogram? __________ Date __________ Where performed __________

Personal History

Marital Status: Married Single Separated Divorced Widowed

Occupation: ______________________ Are you retired? ______

Do you exercise? ______ How often? __________ Type of exercise? ______________

Do yo have pets in the house? (what type) ______________________

Spiritual / Religious preference: ______________

Have you ever been treated for emotional or mental problems? Yes No

What type of treatment did you receive? ______________________

Do you have a Living Will? __________ (Please provide copy to office if Yes)

What is your Code Status? __________

FULL CODE (use of all medical devices to save your life) or **DNR** (do not resuscitate)

Signature ______________________ Date __________

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Social History
Do you use Tobacco Products? ___________
What type of Tobacco? Cigarettes Cigars Pipe Chewing Tobacco Vape
How much per day? ______________
What age did you start? ___________ Have you stopped? _______ When did you stop? ______________
Do you use Alcohol? Rare Social Binge Excessive History of Alcoholism
What do you drink and how many per day? ______________________________________
Do you use Street Drugs? _______________ What and how often? ______________________________
Have you ever been exposed to radiation or asbestos? ______________________________________

Activity History
______ Fully active; normal
______ Have difficulty with strenuous activity; can do light activities (housework, office work)
______ Unable to work; can care for self; out of bed or chair more than 50% of waking hours
______ Can only do limited self-care; stay in bed or chair more than 50% of waking hours
______ Cannot do self-care; confined to bed or chair

Energy level: _______ 0 – 10 (0 = not tired, full of energy 10 = total exhaustion)
How many hours do you sleep at night? _________ Do you nap during day? _________ How long? _________
How is your appetite? Good Fair Poor
Do you have pain? _____________________ Where is your pain? ______________________________
Pain level: _________ 0 – 10 (0 = No Pain 10 = Worst Possible Pain)
What are you currently doing to help your pain? ______________________________________

Hospitalizations and / or Surgeries

Surgery or Hospitalization	Date

Allergies (List all medication / health products /food with which you have had a bad reaction and what reaction occurred)

Allergy	Reaction

Vaccine History (MM/DD/YYYY)
Date of last pneumovax immunization: ____________________
Date of last flue immunization: ____________________
Date of last tetanus immunization: ____________________

Transfusion History
Have you ever had a blood transfusion? Yes No When? ____________________

Colonoscopy
Have you ever had a colonoscopy? Yes No When? ____________________

Family History
List the family member affected by any of the following diseases in the box provided

Disease	Family Member
Blood Disorder	
Cancer – Please list type	
Diabetes	
Hypertension (high blood pressure)	
Hear Disease	
Kidney Disease	
Lung Disease	
Liver Disease	
Seizure Disorder	
Stomach / Gastrointestinal Disease	
Stroke	
Thyroid Disease	

Medications: (Include all prescribed medications, over the counter medications, herbal supplements and vitamins you are taking)

Medication	Dosage	How many times a day

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