New Patient Questionnaire

(Please note – some of the questions are very sensitive in nature and are designed to help your provider to obtain a more complete understanding of your health issues. If you prefer, you can hand the completed form directly to your clinician)

Do you have any health concerns? Please list below :

_____

_____

_____

Chronic Health Issues – Do you suffer from ?:

Health issue	Y/N		Y/N		Y/N
Diabetes		Chronic abdominal pain		Change in a mole	
Hypertension		Heartburn		Pain in muscles or joint	
Headaches		Diarrhea/Constipation		Fatigue	
Hearing Loss		Blood in Stool		Recent Weight Gain or Loss	
Chronic Ear or Sinus Pain		Problems with bowel or bladder control		Depression	
Vision impairment		Frequency of urination		Obsessive- Compulsive Thoughts or Behavior	
Asthma		Nighttime urination		Chronic anxiety	
Chronic cough		History of concussion		Explosive anger	
Chest pain		Headaches		Periods of having too much energy	
Chest tightness at rest or with Exertion		Dizziness or Vertigo		Insomnia	
Shortness of Breath		Weakness of Arm or Leg		Other issues:	
Shortness of Breath only with Exertion		Numbness in Arm/Leg		Other issues:	
Palpitations – heart flutters or skips beats		Chronic rash/dermatitis		Other issues:	

Family History(health issues such as Heart Disease, Hypertension, High cholesterol Diabetes, Cancer and Mental Health Problems)

Mother -_____

Father -_____

Sisters (number and any illnesses) _____

Brother (number and any illnesses) _____

Grandparents - _____

Biological Parents (if different from above) _____

Current Partner (if applicable) _____

Allergies and Sensitivities

List any drug allergies and what the reaction was - _____

List any environmental (e.g. dogs, ragweed) or food sensitivities - _____

Past Medical History

Hospitalizations

Year	Diagnosis

Surgeries

Year	Procedure performed

Medications (include over-the counter supplements too)

Name of Drug Strength in mg. How many times per day

_____

_____

_____

_____

_____

_____

Social History

Home life (circle) - alone, with roommates, partner/spouse, other

Do you Exercise? (circle) - Yes No what type/ how much per week_____

How would you describe your diet? _____

Ever smoke Cigarettes (circle) - No Yes Packs per Day ____ Quit date _____ Planned Quit date _____

Are you employed (circle) Yes No - If Yes, what is your job and do you enjoy it? _____

Going to school? Yes No If Yes then what are you studying _____

Any future career or educational plans? _____

Street Drug use? - present Yes ___ No___ past Yes___ No___

Alcohol use? (circle) None Social Daily

Are you happy with your current social life? _____

Do you wear seatbelts ? (circle) Yes - Usually - Sometimes -No

Contraception - If you were involved in a new relationship would you use condoms? (circle) Yes Always - Yes usually - Sometimes - Rarely - Never

Women's Health

Age when menstrual cycles began: _____

Age when menstrual cycles ended: _____

Problems with menses (pain, irregular, heavy) _____

Problems with libido (interest in sex) _____

Problems with intercourse (such as reaching orgasm, pain)_____

Have you ever felt unsafe in a relationship _____

Have you ever been abused as an adult or child _____

Contraception- What do you use? _____ Any questions/concerns? Yes/No

_____

Men's Health

Problems with libido (interest in sex) _____

Problems with erections (such as obtaining, maintaining, reaching orgasm)_____

Have you ever felt unsafe in a relationship _____

Have you ever been abused as an adult or child _____