

New Patient Questionnaire

Patient Name: _____

Date: _____

REVIEW OF SYMPTOMS

Are you **CURRENTLY** having any of the symptoms listed below?

1. Constitutional:

- Fever: Yes No
- Chills: Yes No
- Sweats: Yes No
- Weight Loss: Yes No

2. Eye/Ear/Nose/Throat:

- Vision Changes: Yes No
- Sore Throat: Yes No
- Pain/Difficulty: Yes No
- Swallowing: Yes No
- Nose Congestion: Yes No

3. Infections:

- HIV: Yes No
- Hepatitis: Yes No
- Boils/Furuncles: Yes No

4. Cardiovascular:

- Chest Pain: Yes No

5. Respiratory:

- Shortness of Breath: Yes No
- Difficulty Breathing: Yes No
- Expectoration: Yes No

6. Gastrointestinal:

- Diarrhea: Yes No
- Stomach Pain: Yes No
- Vomiting: Yes No
- Blood in Stools: Yes No
- Nausea: Yes No

7. Urinary:

- Blood in Urine: Yes No
- Pain with Urination: Yes No

8. Endocrine:

- Thyroid Problems: Yes No
- Diabetes: Yes No

9. Neurological:

- Headache: Yes No
- Migraine: Yes No
- Seizures: Yes No
- Numbness: Yes No
- Weakness: Yes No

10. Musculoskeletal:

- Muscle Aches: Yes No
- Joint Swelling: Yes No
- Joint Pain: Yes No
- Back Pain: Yes No

11. Integumentary:

- Skin Rashes and/or Outbreaks: Yes No

12. Tobacco Use:

- Yes No

13. Former Tobacco Use:

- Yes No

14. Alcohol Use:

- Yes No

15. Drug Use:

- Yes No

16. Travel Outside Country:

- Yes No

Where: _____

When: _____

17. Live With:

18. Occupation:

19. # of Pets: _____

20. Flu Shot this Season: Yes No

OFFICE USE ONLY

Physician Signature: _____ Date: _____

Patient Name: _____ DOB: _____

Referring Physician: _____ Date of visit: _____

Medication Allergies: _____

Preferred Pharmacy: _____ Pharmacy Phone Number: _____

Pharmacy Address: _____

What is the reason you are here today? _____

How has this problem been treated so far? _____

Have you had any testing done yet? CT Scan MRI Bone Scan Cultures

PAST MEDICAL/SURGICAL HISTORY (Have you ever had the following?):

MEDICAL HISTORY

- | | | | |
|--|-------------|--|-------------|
| <input type="checkbox"/> None | | | |
| <input type="checkbox"/> Heart Disease | Date: _____ | <input type="checkbox"/> Lung Problems | Date: _____ |
| <input type="checkbox"/> Diabetes | Date: _____ | <input type="checkbox"/> Depression | Date: _____ |
| <input type="checkbox"/> Hepatitis | Date: _____ | <input type="checkbox"/> Kidney Stones | Date: _____ |
| <input type="checkbox"/> Stroke | Date: _____ | <input type="checkbox"/> GERD/Reflux | Date: _____ |
| <input type="checkbox"/> HIV/AIDS | Date: _____ | <input type="checkbox"/> Thyroid Disease | Date: _____ |
| <input type="checkbox"/> Cancer | Date: _____ | <input type="checkbox"/> Blood Clots/DVT | Date: _____ |

SURGICAL HISTORY

- | | | | |
|--|-------------|--|-------------|
| <input type="checkbox"/> None | | | |
| <input type="checkbox"/> Heart Valve | Date: _____ | <input type="checkbox"/> Joint Replacement | Date: _____ |
| <input type="checkbox"/> Cardiac Cath. | Date: _____ | <input type="checkbox"/> Pacemaker/Defibrillator | Date: _____ |
| <input type="checkbox"/> Angioplasty/Stent | Date: _____ | <input type="checkbox"/> Bone or Spine Surgery | Date: _____ |
| <input type="checkbox"/> Cardiac Surgery | Date: _____ | <input type="checkbox"/> Other Surgeries | Date: _____ |

Other Illnesses: _____

Other Surgeries: _____

Family History: Auto Immune Lupus Rheumatoid Arthritis Psoriatic Arthritis Cancer Other: _____

PATIENT SIGNATURE: _____ DATE: _____