NEW PATIENT QUESTIONAIRE

What problem/s brought you here?

_____

_____

History of present illness

Please describe the location of your problem:

_____

How long have your symptoms been present_____

List any MEDICAL problems (diabetes, cancer, infections, etc) that you have had in the past, including the dates, if possible:

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

List any SURGERIES that you have had in the past, including dates, if possible:

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

List current medications:

Name	Dose	Per day
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

PATIENT NAME / LABEL:

DOB :

Do you have any drug allergies?

☐ Yes ☐ No

If Yes, please list your below:

_____

_____

_____

_____

_____

Do any diseases or cancers run in your family? Please list:

_____

_____

_____

_____

Social History

Are you working? ☐ Yes ☐ No

Occupation _____

Do you smoke? ☐ Yes ☐ No

How much/day? _____

Do you drink alcohol? ☐ Yes ☐ No

How much/day? _____

Do you use drugs? ☐ Yes ☐ No

What kind? _____

Signed .....