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:

_____ _____

_____ _____

_____ _____

_____ _____

□ None

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

_____ _____

_____ _____

_____ _____

_____ _____

□ None

List current medications:

Name Dose Per day

_____

_____

_____

_____

_____

□ Nil medications

PATIENT NAME / LABEL:

DOB :

Do you have any drug allergies?

☐ Yes ☐ No

If Yes, please list your below:

_____

_____

_____

Do you have asthma or use inhalers?

☐ Yes ☐ No

If Yes, please confirm how often:

☐ Regular use ☐ intermittent only

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

_____

_____

_____

_____

Social History

Are you working? ☐ Yes ☐ No

Occupation _____

Have you ever smoked? ☐ Yes ☐ No

If yes, when did you last smoke?

☐ <12mths or

☐ Age you quit ____ yro

The age you started smoking: _____ yro

How many (cigarettes)/day? _____

Do you drink alcohol? ☐ Yes ☐ No

How many (drinks) /day? _____

How many alcohol free days/week? _____

Do you use recreational drugs? ☐ Yes ☐ No

What kind? _____

Signed ..... Date .....