New Patient Medical Questionnaire

PATIENT HISTORY QUESTIONNAIRE NEW PATIENT YEARLY PHYSICAL

Patient Name: _____ Date: _____

What is the primary reason for your visit today? _____

When was the last time you had a full Physical? _____

Dr's Name:_____ Phone #:_____

What symptoms are you experiencing and how long have your had them?

_____
_____
_____

What treatment have you had towards these symptoms and when?

_____
_____
_____

Primary language spoken: _____

Medical and Surgical History

List hospitalizations, surgeries, and serious injuries

_____

_____

_____

Have you ever had the following?		
Diabetes	Yes	No
Hypertension	Yes	No
Cancer	Yes	No
Heart trouble	Yes	No

Social History (check all that apply)

Marital: Single Married Separated Divorced Widowed

Alcohol: Never Rarely _____ drinks/week

Tobacco: Never Quit _____ packs/day for _____ years

Drugs: Never Have used Use Type: _____

Caffeine (coffee/soft drinks) amount per day: _____

Prolonged exposure to: Fumes Dust Solvents Noise

Do you feel safe in your home? _____

Do you feel sad or cry at time for no reason? _____

Do you presently have any problems in the following areas?
If "Yes" Please Explain

Eyes:	Yes	No _____
Ears, Nose, Mouth,	Yes	No _____
Cardiovascular (heart)	Yes	No _____
Respiratory (lungs/breathing)	Yes	No _____
Gastrointestinal (stomach)	Yes	No _____
Genitourinary (genitals, kidney,)	Yes	No

Cancer Screening History

Please provide the dates and results of the most recent testing.

Colonoscopy: _____

Mammogram: _____

Pap smear: _____

Family Medical History

Specify current health status or cause of death, age or age at death

Medical Problems.

Father: Alive _____ Yes _____ No Age at death _____

Reason for death: _____

Mother: Alive _____ Yes _____ No Age at death _____

Reason for death: _____

List your current medications and dosages

	NAME	DOSAGE
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____
5.	_____	_____
6.	_____	_____
7.	_____	_____

Siblings

Age	Alive	Illness
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Children

Age	Sex	Health
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

WOMAN ONLY

Age menstrual period began _____ Is it **Regular** or **Irregular**

Date of last period _____ Do you have Spotting in between **Yes** **No**

Length of period _____ days Flow is **Heavy** **Medium** **Light**

Allergies

_____

_____

Patient's signature:

_____

_____

Physician Signature: