New Patient Health History Questionnaire

All questions contained in this questionnaire are strictly confidential and will become a part of your medical record.

Name First, Middle, & Last		**Gender:** ☐ Male or ☐ Female	
Date of Birth (MM/DD/YYYY):	**SSN:** ___ ___ ___-___ ___-___ ___ ___ ___		
Marital Status:	☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed		
Address:	**Apt:**	**City:** **State:**	**Zip code**
Home Phone: ( ) __ __ __ - ___ ___ ___ ___		**Cell Phone:** ( ) ___ ___ ___ - ___ ___ ___ ___	
Email:			
Emergency Contact/Next of Kin: Name (Last, First)		**Main Phone Number:** ( ) ___ ___ ___- ___ ___ ___ ___	
PREFERRED PHARMACY & LOCATION:			
Insurance Company (Name):			**Self Pay Patients: Deposit** Leave $100 at front desk. Payment made by Cash or Credit Only

Past Medical History

Past Surgical History: Please, list all previous surgeries you have had.

Date of Surgery	Type of Surgery

Medical Allergies: Please, list all known allergies to medications, food, or environmental allergies.

Name of Source	Type of Reaction

Current Medications: Please, list all current medications you are taking.

Name of Medication	Strength/Dosage	How many times per day?

Health and Lifestyle Habits				
Exercise Level	☐	None		
	☐	Mild (walk 3 blocks, up the stairs, play golf)		
	☐	Occasional rigorous exercise (work or recreation, less than 4 times per week for 30 min		
	☐	Regular rigorous exercise (work or recreation 4 times or more per week for 30 minutes		
Diet & Nutrition	Are you currently dieting?			☐ Yes ☐ No
	If yes, are you on a physician supervised diet?			☐ Yes ☐ No
	Number of Meals per day?_____	Salt Intake ☐ High ☐ Med ☐ Low	Fat Intake ☐ High ☐ Med ☐ Low	
	Do you drink caffeine?			☐ Yes ☐ No
	If yes, what type?	☐ Coffee ☐ Tea ☐ Soda	How Many cups per day?_____	
Alcohol	Do you drink alcohol? If yes, how often? If no, skip to next question.		☐ Daily ☐ Occasional ☐ Never	
Tobacco Usage	Do you use tobacco products?	☐ Yes ☐ No	☐ Daily ☐ Occasional ☐ Never	
Drug Usage	Do you use recreational drugs?			☐ Yes ☐ No
	Have you ever used a needle to inject yourself with a drug?			☐ Yes ☐ No
Personal Safety	Do you live alone?			☐ Yes ☐ No
	Do you fall frequently?			☐ Yes ☐ No
	Do you have loss of hearing or vision?			☐ Yes ☐ No

Family History of Medical Conditions Information			
Relationship to You	Problem	Deceased? Yes or No	At what age did this person pass away?

Medical Problem History

Check all conditions you currently have or a condition that a doctor has told you that you have:

☐ Anemia	☐ Gynecological Problems
☐ Anxiety	☐ Hay Fever
☐ Arthritis	☐ Heart Disease/Heart murmur
☐ Asthma	☐ Heartburn/Reflux
☐ Back Problems	☐ High Blood Pressure
☐ Cancer: What type?	☐ Kidney/Bladder Disease
☐ Cataracts	☐ Liver Disease/Hepatitis
☐ Chest Pain	☐ Loss of Hearing
☐ Depression	☐ Loss of Vision
☐ Diabetes	☐ Migraines
☐ Diarrhea	☐ Osteoporosis
☐ Difficulty breathing	☐ Palpitations (heart racing)
☐ Difficulty breathing/loss of breath while sleeping	☐ Peptic Ulcer
☐ Difficulty breathing/loss of breath while sitting still	☐ Seasonal Allergies (sneezing, cough, itchy eyes)
☐ Dizziness	☐ Seizures
☐ Emphysema	☐ Tingling in your hands or feet
☐ Extra Heart beats	☐ Thyroid Disease
☐ Skipped heart beats	☐ HIV or other STD
☐ Glaucoma	