Name: _____ Date of Birth: __ / __ / _____

NEW PATIENT MEDICAL QUESTIONNAIRE

Current Medical Problems:

1. _____ 5. _____
2. _____ 6. _____
3. _____ 7. _____
4. _____ 8. _____

Past Medical / Surgical History:

1. _____ 5. _____
2. _____ 6. _____
3. _____ 7. _____
4. _____ 8. _____

Current Medications (include dosage):

1. _____ 5. _____
2. _____ 6. _____
3. _____ 7. _____
4. _____ 8. _____

Current Supplements/Vitamins/Herbs/Homeopathic remedies:

1. _____ 5. _____
2. _____ 6. _____
3. _____ 7. _____
4. _____ 8. _____

Allergy to Medications: (Encircle) YES NO

If Yes, what? _____

_____

Family Medical History: (Encircle) Medical problems

Father	alive	deceased	_____
Mother	alive	deceased	_____
Brother/s	alive	deceased	_____
Sister/s	alive	deceased	_____
Children	alive	deceased	_____
Grandchildren	alive	deceased	_____
Grandparents:			
Father-side			
	alive	deceased	_____
Mother-side			
	alive	deceased	_____
Others:	alive	deceased	_____