



New Patient Questionnaire

In order to best serve your medical needs, we ask that you complete the following questionnaire as completely as possible. The **Health Care Consumer (HCC) - Health Care Provider (HCP)** relationship is a privileged relationship built on trust and honesty. By completing and signing this form, you acknowledge that you understand that any intentionally false or omitted information may seriously and adversely affect your path to better health.

Patient Name _____ Gender M F
Last First Middle

Date of Birth (MM/DD/YYYY) ____/____/____

Address: _____ City: _____ State: _____ Zip: _____

If the person completing this form is not the patient, please write your name, your relationship to the patient, and why you are completing the form for this patient.

Name _____ Relationship _____ Reason _____

Reason For Visit (please explain in detail): _____

Patient's Personal Contact Information: (Please circle which you prefer.)

Email: _____ (used only with your permission)

Home Phone: (____) _____ Work Phone: (____) _____

Cell Phone: (____) _____

Emergency Contact:

Address _____ Home Phone: _____

Address _____ Work Phone: _____

Have you completed a Living Will OR designated a Durable Power of Attorney for Health Care? Yes No

If yes, please provide a copy for your health care provider.

Do you have any religious or cultural beliefs that may impact your health care? Yes No

If yes, please describe (e.g.: food preferences/restrictions; medications; sleep practices; etc.):

Please let us know who referred you to us: _____

Preferred methods of learning new material are: Verbal Instruction Written Instruction Handouts Visual (Pictures, Videos, etc)

You Do You Do Not understand English well. The language you prefer _____

Names and Phone Numbers for Health Care Providers (HCPs) from whom you are currently receiving care (or have seen within the past 12 months), and ANY Health Care Providers from whom you are obtaining prescriptions.

_____ Contact # _____
_____ Contact # _____
_____ Contact # _____
_____ Contact # _____
_____ Contact # _____

Please list *all* of the medications you are taking or have taken (if you no longer take something, then please indicate how long you took it). Also, include over the counter medications, supplements, homeopathics, herbs & vitamins.

<i>Name</i>	<i>Dose</i>	<i>Last taken</i>	<i>Name</i>	<i>Dose</i>	<i>Last taken</i>
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Please list and describe allergic reactions you have had to food, medications or insect stings.

Check if you are you allergic to Shellfish _____ IV Contrast Dye _____ Penicillin _____

Please list Food, Medication or Insect Allergy Reactions

_____	_____
_____	_____
_____	_____
_____	_____

Please list your occupations. Include the length of time you performed in that role, and describe your work responsibilities in that occupation. (Include military experience.)

Occupation	Start Date	Stop Date	Responsibilities
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Have you ever been exposed to known cancer causing agents or inhalation hazards? Yes No

Examples: asbestos, paints, aniline dyes, chemicals, silica, solvents, PCBs, pesticides, etc.

If yes, please list types of exposure, time period exposed, and health problems experienced at time of exposure:

Agent	Start Date	Stop Date	Health problems resulting from exposure (if known)
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Please list your hobbies.

Have you traveled, in the past 12 months? Yes No

If so, please describe where, when, and for how long you were there.

Travel destinations OUTSIDE the United States Dates and time spent there.

Travel destinations INSIDE the United States Dates and time spent there.

Do you exercise? Yes No If yes, describe the activity, how long and how often you exercise on average each week:

How many minutes of sun exposure do you receive daily and about what time of day? _____

What percentage of this time do you wear sunglasses? _____

How much of this time do you have SPF applied? _____

In the past 12 months, have you fallen? Yes No If yes, how many times? _____

Have you ever broken bones, or sustained an injury, as a result of falling? Yes No

Do you have a history of smoking? Yes No If yes, _____ # packs per day X _____ for # years

Have you ever chewed tobacco? Yes No

Have you ever smoked pipes or cigars? Yes No If yes, how many cigars or bowls _____ per _____ Day _____ Week

Have you quit? If so, when: Yes No _____/_____/_____

Have you considered quitting? Yes No If yes, have you set a date to quit? Yes No

Have you tried quitting? Yes No If yes, what is the longest time period you quit smoking? _____

Do you have a history of alcohol use? Yes No If yes, specify _____ # drinks per Day Week

(One "drink" is equal to 12 oz. can of beer, 1.5 oz. liquor (80 proof) or 5 oz wine.)

Have you ever experienced a blackout, or loss of consciousness due to alcohol intake? Yes No

Have you ever needed to drink to prevent yourself from shaking, sweating, and becoming irritable? Yes No

Have you ever been arrested or ticketed for DUI (Driving Under the Influence)? Yes No

Have you been involved in any motor vehicle accidents in the past 12 months? Yes No

Do you use drugs for recreational purposes? Yes No

If yes, check all that apply Amphetamines Cocaine Marijuana Heroin Inhalants LSD Other: _____

Method of delivery you chose Ingestion Injection Inhalation

How much would you use _____

How long did you use drugs _____

Have you quit? Yes No If so, when _____

Have you ever taken drugs to prevent shaking, sweating and becoming irritable? Yes No

Have you ever had a problem with addiction to prescription pain medication or benzodiazepines? Yes No

If yes, specify when and which drugs. _____

Are you sexually active? Yes No

If so, do you practice birth control of any kind? Yes No If yes, check below all that apply:

Condoms Diaphragm IUD (Intrauterine Device) Birth Control Pills, Patches, Implants

Have you EVER been diagnosed with a sexually transmitted disease (like syphilis, gonorrhea or HIV), or were you exposed to a sexually transmitted disease during childbirth? Yes No

Do you have any tattoos or body piercings? Yes No

Have you received any transfusions of blood or blood products? Yes No

Describe your seatbelt use when you are driving, or a passenger in a vehicle:

All the time Most of the time About half the time Rarely Never

Can you perform your own hygiene, dressing, cooking and shopping needs independently? Yes No

Do you feel safe in your current relationship? Yes No

Have you ever been in a relationship where you were threatened, hurt or afraid? Yes No

Have you ever had the following exams, if more than once, then please list the most recent?

If so describe when and why:

- 3D CT Dental Scan Yes No ____/____/____
- PAP Smear Yes No ____/____/____
- Prostate Biopsy Yes No ____/____/____
- Mammogram Yes No ____/____/____
- Breast Thermograph Yes No ____/____/____
- Colonoscopy Yes No ____/____/____
- EGD (Esophageal endoscopy) Yes No ____/____/____
- EKG Yes No ____/____/____
- Cardiac stress test Yes No ____/____/____
- ECHO Yes No ____/____/____
- Chest x-ray Yes No ____/____/____
- CT "CAT" scan of chest Yes No ____/____/____
- Pulmonary function test Yes No ____/____/____
- EEG or QEEG Yes No ____/____/____
- Bone density test (DEXA) Yes No ____/____/____
- Visual Field Study (VFS) Yes No ____/____/____
- Meridian Assessment Yes No ____/____/____
- Lab/blood work (specify) Yes No ____/____/____
- Other exams/tests not listed.** Yes No ____/____/____

Have you had any of the following vaccinations? Check all that apply, and specify when last received.

- Yes No Influenza (Flu shot) _____
- Yes No Pneumonia _____
- Yes No Tetanus _____
- Yes No BCG _____
- Yes No Varicella _____
- Yes No HPV (Gardasil) _____
- Yes No Other (circle) MMR/IPV/Smallpox/HBV/DTaP/Td/Hib/Chickenpox/PCV/MCV4/Rubella/Mumps

If you are female, have you ever been pregnant? Yes No

Number of pregnancies? _____ Number of live births? _____ Number of miscarriages or abortions? _____

Age of onset of menstrual cycles? _____ Age of onset of menopause? _____ NA

Have you ever taken birth control pills, or used birth control patches or implants? Yes No

If yes, what did you take and for how long? _____

Have you ever been on hormone replacement therapy? Yes No

If yes, what did you take and for how long? _____

Did you ever have an IUD? Yes No If yes, was it removed? Yes No If yes, when ____/____/____

How often do you eliminate your bowels per day _____ per week _____?

When was the last time you were on an antibiotic and for what reason? _____

Have you used antibiotics more than once in the last 3 years? Yes No

Have you ever needed a steroid? Yes No When? _____ Reason? _____

Did it work and to what extent did it help? _____

Past Medical History Please check all that apply-resolved and current:
 (Note: none of this information is shared with anyone outside of this office without your prior consent.)

Adrenal Dysfunction Yes No
 Alzheimer Yes No
 Amyotrophic Lateral Sclerosis Yes No
 Anorexia or Bulimia Yes No
 Anxiety Disorder Yes No
 Arteriovenous Malformations (AVMs) Yes No
 Arthritis Yes No
 Asthma Yes No
 Autoimmune Disease Yes No
 Bipolar Disorder Yes No
 Bleeding Disorder Yes No
 Cataracts Yes No
 Cerebrovascular Accident (Stroke) Yes No
 Chemotherapy If yes, state when and duration: Yes No

Hemorrhoids Yes No
 Hepatitis Yes No
 HIV or AIDS Yes No
 Hypertension Yes No
 Hyperthyroidism Yes No
 Hypotension Yes No
 Hypothyroidism Yes No
 Inflammatory Bowel Disease Yes No
 Irregular Heart Rhythm Yes No
 Kyphosis Yes No
 Liver Dysfunction Yes No
 Lyme's or related infections Yes No
 Kidney Failure, or Dysfunction Yes No
 Malignancy If yes, describe below Yes No

Claudication Yes No
 Clotting Disorder Yes No
 Congenital Heart Defects Yes No
 Coronary Artery Disease Yes No
 COPD Yes No
 Cystic Fibrosis Yes No
 Depression Yes No
 Diabetes Yes No
 Dialysis Yes No
 Eclampsia or Pre-eclampsia Yes No
 Endocarditis Yes No
 Endometriosis Yes No
 End Stage Renal Disease Yes No
 Erectile Dysfunction Yes No
 Esophageal Dysfunction Yes No
 Fibromyalgia Yes No
 Gallstones Yes No
 Gastritis or Gastric Ulcers Yes No
 GERD (reflux problems) Yes No
 Glaucoma Yes No
 Heart or Valve Defects Yes No
 Hemochromatosis Yes No

Mania Yes No
 Muscular Dystrophy Yes No
 Myocardial Infarction (Heart Attack) Yes No
 Narcolepsy Yes No
 Obstructive Sleep Apnea Yes No
 Organ Transplant If yes, describe Yes No

Osteoporosis Yes No
 Pancreatitis Yes No
 Periodic Limb Movement Disorder Yes No
 Peripheral Artery Disease Yes No
 Personality Disorder Yes No
 Pituitary Dysfunction Yes No
 Polycystic Ovarian Syndrome Yes No
 Pulmonary Artery Hypertension Yes No
 Pulmonary fibrosis Yes No
 Radiation Therapy If yes, explain: Yes No

Recurrent Infections Yes No
 (bacterial, viral, parasitic, etc.)
 Restless Leg Syndrome Yes No
 Sarcoidosis Yes No

- Schizophrenia Yes No
- Scleroderma Yes No
- Scoliosis Yes No
- Seizure Disorder Yes No
- Sickle Cell Yes No
- Sjogren's Yes No

- Skin Disorders (Psoriasis, Acne, Eczema) Yes No
- Thalassemia Yes No
- Thrombocytopenia Yes No
- Thrombophilia Yes No
- Transfusions Yes No

Review of Systems In the last *6 months*, have you experienced any of the following symptoms ***either resolved or current?***
Respond to each.

Constitutional

- Weight Loss or Gain Yes No
- Appetite changes (increased or decreased) Yes No
- Fatigue, profound and impairs daily function Yes No
- Fever Yes No
- Shakes/sweats from lack of alcohol or drug Yes No

Eyes

- Eye pain or drainage Yes No
- Visual changes Yes No
- Dry, irritated eyes Yes No

ENT/Mouth

- Ear pain or drainage Yes No
- Frequent sinus infections Yes No
- Hearing changes or loss Yes No
- Nosebleeds Yes No
- Dizziness Yes No

Respiratory

- Blood in your sputum Yes No
- Chest tightness Yes No
- Cough lasting >1 month, productive or not Yes No
- Shortness of breath Yes No
- Wheezing Yes No
- Chest pain with inhalation or coughing Yes No

Cardiovascular

- Chest pain or heaviness Yes No
- Palpitations Yes No
- Fainting or near fainting spells Yes No
- Swelling of feet or legs Yes No
- Shortness of breath lying flat in bed Yes No

Gastrointestinal

- Abdominal pain Yes No
- Blood in your stool Yes No
- Constipation Yes No
- Diarrhea or Food Intolerance Yes No
- Heartburn or Indigestion Yes No
- Vomiting or nausea lasting for >1 day Yes No
- Swallowing difficulty Yes No

Psych

- Anxiety without clear explanation Yes No
- Sadness lasting for days or weeks Yes No
- Hearing voices Yes No
- Thoughts of hurting yourself Yes No
- Thought of hurting others Yes No
- Fear of people, places or things Yes No

Genitourinary

- Blood in your urine Yes No
- Menstrual changes Yes No
- Urinating that is painful or difficult Yes No
- Erection problems Yes No
- Vaginal discharge or bleeding Yes No

Musculoskeletal

- Broken bones Yes No
- Joint pain or swelling Yes No
- Muscle aches Yes No
- Muscle weakness Yes No
- Back pain Yes No

Skin/Breasts

- Masses or lumps Yes No
- Nipple discharge Yes No
- Rashes or nonhealing ulcers Yes No

Neurologic

- Seizures Yes No
- Coughing or choking with swallowing Yes No
- Excessive daytime sleepiness Yes No
- Extremity pain or burning sensations Yes No
- Hallucinations Yes No
- Numbness or tingling Yes No
- Difficulty falling asleep, staying asleep Yes No

Endocrine

- Hair loss Yes No
- Frequent urination Yes No
- Increased thirst Yes No
- Heat or cold intolerance Yes No

Blood/Lymph

- Bleeding from gums or nose Yes No
- Unexplained bruising Yes No
- Night Sweats Yes No
- Swollen, painful lymph nodes Yes No

Allergy/Immune

- Watery eyes Yes No
- Runny nose Yes No
- Food intolerance Yes No
- Frequent skin sores Yes No
- Itching Yes No
- Reactions to foods: Yes No

-belching; racing heart; sleepy; gas; bloating; ringing in the ears; itchy ears; or runny nose.

Please list all surgical procedures you have had. Please include surgeon and date of procedure.

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Family Medical History Please list all known medical problems in your immediate family.
(Specify M=Mother, F=Father, B=Brother, S=Sister, So=Son, D=Daughter, GM=Grandmother, GF=Grandfather)

Please list your goals for your health and any additional information you feel would be helpful.

I hereby declare that the information furnished above is true to the best of my knowledge and beliefs.

Name: _____

Signature: _____ **Date:** ____ / ____ / ____

[To ensure accuracy and efficiency, all 7 pages must be returned prior to your first visit. Thank you for your cooperation.]

Physician's Notes
