

New Patient Questionnaire

Patient Name: _____ Occupation: _____
 Employer: _____ Date of Birth: _____
 Today's date: _____
 Name of your primary care physician: _____
 Name of referring physician/person: _____

CHIEF COMPLAINT:

What brings you here? _____

HISTORY:

Date symptoms started/accident occurred _____
 Body part(s) _____ Left Right
 Please Describe _____

Did your Symptoms / Accident occur at?

Work School Motor Vehicle Public Facility Private Residence

List any treatments or tests you have had for this problem:

- o Medications: _____
- o Physical Therapy: _____
- o X-rays or other tests: _____

Names of Other Treating Physicians: 1) _____ 2) _____

PAST MEDICAL HISTORY:

| PROBLEM | No | Yes | When? | Description |
|------------------------------|----|-----|-------|-------------|
| Heart Disease | | | | |
| Diabetes | | | | |
| High Blood Pressure | | | | |
| Cancer (type?) | | | | |
| Lung/Breathing problem | | | | |
| Stomach/intestine problem | | | | |
| Circulation problems | | | | |
| Bleeding/Clotting problem | | | | |
| Neurological (type?) | | | | |
| Hepatitis/Infectious disease | | | | |
| Thyroid disease | | | | |
| Arthritis (type?) | | | | |
| Broken bones | | | | |
| Severe sprains | | | | |
| Dislocations | | | | |
| OTHER problems | | | | |

List all past **SURGERIES** and dates:

MEDICATIONS: (Please list all)

Please complete other side → →

ALLERGIES: (Any medications or environmental)

Yes No

Please List: _____

Are you allergic to *Latex*? Yes No

SOCIAL HISTORY:

Living situation: (check if applies)

Single Married Widowed Separated
 Divorced

Highest grade of school completed:

(Give year or degree)

Elementary _____ High School _____

College _____ Post Graduate _____

Number of people living at your home:

(Include yourself) _____

VITALS:

Right-handed Left-handed Both

Height: _____ Weight: _____

PERSONAL HISTORY:

Do you use tobacco? Yes No Quit

Cigarettes Cigars Smokeless

Pack(s) per day _____ # of years _____

Do you use alcohol? Yes No Rarely

Drink(s) per day _____ per week _____

Do you exercise regularly? Yes No

How often? _____

Type/Activity: _____

Please list your hobbies/interests:

For Workman's Compensation Cases ONLY:

Date of injury _____

First date of disability _____

Are you now out of work? _____

If out of work now, who has taken you out of work?

Last date that you worked _____

FAMILY HISTORY: Please list any major illnesses in family members living or deceased

| | Age | Living | Deceased | Describe major illnesses in family member or cause of death |
|----------|-----|--------|----------|---|
| Mother | | | | |
| Father | | | | |
| Brothers | | | | |
| | | | | |
| Sisters | | | | |
| | | | | |
| Children | | | | |
| | | | | |
| | | | | |
| | | | | |

REVIEW OF SYSTEMS (Check System and words that apply to you)

- Gastrointestinal:** bleeding ulcers hiatal hernia frequent indigestion colitis
- Genitourinary:** *Urination that is:* frequent burning painful bloody
- Neurological :** paralysis weakness numbness seizures
 tingling in arms left right tingling in legs left right
- Skin:** rashes frequent itching wounds that do not heal infections
 boils
- Vascular & Hematological & Lymphatic:** vein problems phlebitis clots anemia
 bleeding problems calf pain on exertion
 easy bruising swollen nodes
- Cardiac & Pulmonary:** chest pain shortness of breath enlarged heart
 Irregular heart beat heart murmur wheezing cough
- Endocrine:** thyroid problems weight loss weight gain excessive sweating
 tremor
- All Others Negative**

Date: _____

MD/PA Signature: _____

Reviewed: Date: _____

Initials: _____ No Changes Changes Noted

Reviewed: Date: _____

Initials: _____ No Changes Changes Noted

Reviewed: Date: _____

Initials: _____ No Changes Changes Noted

Please provide any other insights, information or concerns that you feel might be helpful in your care.

* This is a confidential record of your medical history and will be kept in your chart. Information contained here will not be released except when you have authorized us to do so.

Thank you for completing this form !!