New Patient Medical History Questionnaire

Name: Date of Birth: Age: Date:

Governmental mandates require our office to ask the next 3 questions. Please circle the most appropriate answers.

What is your Race? African American, Alaskan Native, Asian, Caucasian, Hispanic, Native American, Native Hawaiian, Other Pacific Islander, Other Race, Refuse to Report

Do you have any Hispanic or Latin decent? Yes / No / Refuse to Report

Primary Language Spoken: _____

Please list all current prescription medications and over the counter medications:

Medication	Dosage	When taken	Who wrote the prescription	Reason taking medication
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

Please list any Specialists that you are seeing and the condition that you are treating:

Doctor	Condition	Doctor	Condition
1.		4.	
2.		5.	
3.		6.	

Please circle any of the following that pertains to your past medical history:

Blood Clots	High blood pressure	Drug Addiction	Migraines	Memory Trouble
Hearing Trouble	Asthma	Depression/Anxiety	Mental Illness	Seizures
COPD	Diabetes	Cancer	High Cholesterol	Sleep apnea

Please list any allergies and the corresponding reactions:

Medications:

Food:

Environmental/Chemical:

Please list any operations you have had and the year you had it:

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Have you ever received a blood transfusion? Yes / No

Please list overnight hospitalizations, include why and the year (including child birth):

Please list the current status of your immediate family:

	Please Circle	Age (Now or at Death)	Comments/Cause of Death
Mother	Alive / Deceased		
Father	Alive / Deceased		
Maternal Grandma	Alive / Deceased		
Maternal Grandfather	Alive / Deceased		
Paternal Grandma	Alive / Deceased		
Paternal Grandfather	Alive / Deceased		
Sibling 1	Alive / Deceased		
Sibling 2	Alive / Deceased		
Sibling 3	Alive / Deceased		
Sibling 4	Alive / Deceased		

Are you? Single Married Divorced Widowed

What is your highest level of education completed?

What is your occupation?

Who do you live with?

Do you have pets? Yes No Type:

Do you exercise? Yes No Times a week

Do you drink caffeine? Yes No _____ How many cups a day? (Including coffee, energy drinks, etc.)

Have you ever used recreational drugs such as marijuana, cocaine, heroin, amphetamines, etc.? Yes No

If yes, what type? _____ _____ How often? _____ Year you quit?

Do you smoke cigarettes? Yes No _____ How many packs a day? _____ Year you quit?

Do you chew tobacco? Yes No _____ How much? _____ Year you quit?

Do you drink alcohol? Yes No _____ How many drinks a week?

Have you ever had a problem with alcohol on the past? Yes No _____ Year you quit?

Have you ever been a victim of emotional, physical, or sexual abuse as a child or adult? Yes No

Are you sexually active? Yes No

When was your last Tetanus shot? N/A

When did you have your HPV series? N/A

When was your last Pneumonia immunization? N/A

When was your last Shingles immunization? N/A

When was your last Hepatitis B immunization? N/A

When was your last eye exam? N/A

When was your last colonoscopy? N/A

Women Only:

When was your last pap?

When was your last mammogram?

When was your last DEXA?

Men Only:

When was your last PSA test?

When was your last DEXA?

Signature: Date: