NEW PATIENT PRE-APPOINTMENT QUESTIONNAIRE

Name: _____ DOB: _____ Age: _____ Sex: ____Male ____Female

Do you see any other doctors?

Doctor's Name	Speciality	Reason

Which of the following conditions are currently being treated or have been treated for in the past?

___ Allergies	___ Asthma	___ Arthritis	___ Anxiety/panic	___ Anemia
___ Abnormal EKG	___ Alcoholism	___ Acid reflux	___ Blood Clots	___ Bleeding problems
___ Blood Transfusion	___ Back pain	___ Breast lumps	___ Cancer	___ Chest Pain
___ Colitis	___ Concussion	___ Cold Sores	___ Constipation	___ Diabetes
___ Depression	___ Dizziness	___ Diarrhea	___ Drug overdose/abuse	___ Eczema
___ Emphysema/COPD	___ Erectile dysfunction	___ Epllepsy/Seizures	___ Glaucoma	___ Gallbladder disease
___ Genital herpes	___ Gout	___ Headaches	___ Hearing Problem	___ Hernia
___ Heart attack	___ Heart murmur	___ Heart disease	___ Hepatitis	___ Herniated disk
___ High blood pressure	___ Hemorrhoids	___ Heart failure	___ High cholesterol	___ HIV/AIDS
___ Hodgkin's	___ Insomnia	___ Irritable Bowel	___ Kidney disease	___ Kidney stones
___ Liver disease	___ Leukemia	___ Lung problems	___ Lupus	___ Meningitis
___ Migraines	___ Muscle disease	___ OCD	___ Pancreatitis	___ Pneumonia
___ Psoriasis	___ Polio	___ Sickle cell disease	___ Stroke	___ Skin disease
___ Sinus disease	___ Suicide attempt	___ Thyroid disease	___ Tuberculosis/Positive TB test	
___ Ulcer disease	___ Urinary infections	___ Other _____		

SEVERE INJURIES

Please list dates and details of any injuries you have ever had _____

_____

ALLERGIES TO ANY MEDICATIONS, X-RAY DYES OR OTHER SUBSTANCES? Yes_____ No _____

(If yes, please list name of medication and type of reaction) _____

_____

GYN HISTORY

Date of last period: _____ Do you suffer from PMS? ___ YES ___ NO Date of your last pap smear _____

Have you ever had an abnormal pap? ___ YES ___ NO If yes, date and results _____

Pregnancies: Total Number _____ Full Term _____ Miscarriages _____ Abortions _____ Premature _____ Tubal _____

Complications/Pregnancy related illness _____

Date of your last mammogram _____Where?_____ Date of your last bone density test _____