

**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?**

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