

NEW PATIENT PRE-APPOINTMENT QUESTIONNAIRE

Name: _____ DOB: _____ Age: _____ Sex: ___ Male ___ Female

Do you see any other doctors?

| Doctor's Name | Speciality | Reason |
|---------------|------------|--------|
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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 _____