

## New Patient - Medical Questionnaire

Name: \_\_\_\_\_

Date: \_\_\_\_\_

**Allergies** Please list all medication and/or other allergies that you have.

Allergies	Allergies	Allergies

**I. Medications** Please list all prescription and non-prescription medications or supplements you are taking.

Medication	Dosage	Medication	Dosage

**II. Medical History:** Please list any current medical conditions, previous hospitalizations, and/or surgeries.

Medical Condition	How Long	Medical Condition	How Long

Previous Hospital and/or Surgery	Approx Date	Previous Hospitalization and/or Surgery	Approx Date

**III. Family History** Please list your parents and siblings. If they have/had any health problems, please indicate.

Relation	Year of Birth	Age of death if Applies	Medical Problem(s)
Father			
Mother			
Brother/Sister			
Brother/Sister			
Brother/Sister			
Brother/Sister			
Brother/Sister			
Brother/Sister			
Brother/Sister			

**Has any blood relative ever had:**

Cancer....._	Hypertension....._
Heart Disease....._	Glaucoma....._
Diabetes....._	Other inherited problem....._

**If the answer to any of the above is yes (and you did not list it above) please list:**

Relation	Medical Problem

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### IV. Habits

Please answer the following:

**A. Smoking:**

Have you ever smoked or used smokeless tobacco?.....  Yes  No **If no proceed to B below.**

At what age did you start? \_\_\_\_\_ How many packs/pkgs a day? \_\_\_\_\_ Cigars? \_\_\_\_\_ Pipe? \_\_\_\_\_

Do you smoke or use smokeless tobacco now?  Yes  No If no, when did you stop? \_\_\_\_\_ years ago.

**B. Alcohol:**

Have you ever drank Alcohol?.....  Yes  No **If no proceed to C below.**

Do you drink now?  Yes  No If no, when did you stop? \_\_\_\_\_ years ago.

If yes, how often do you drink? \_\_\_\_\_ days a week/month (**circle one**) How many drinks a day? \_\_\_\_\_

Have you ever tried to cut down on your drinking?.....  Yes  No

Have you ever been annoyed by criticism of your drinking?.....  Yes  No

Have you ever felt guilty about your drinking?.....  Yes  No

Have you ever had a morning "eye-opener"?.....  Yes  No

**C. Other substance use:**

Have you ever used any illicit or illegal drugs?.....  Yes  No

**D. Do you wear seatbelts?.....  Always  Usually  Never**

**E. Do you exercise regularly? Yes  No  How often? \_\_\_\_\_ What type of exercise? \_\_\_\_\_**

### V. Social History

**A. Occupation**

Are you employed?  Retired  What is/was your occupation? \_\_\_\_\_

**B. Are you exposed to any hazardous substances at work? Yes  No  If yes, what? \_\_\_\_\_**

**C. Are you married?  Single  Divorced?  Widowed?**

**D. Do you have children at home? Yes  No  How many? \_\_\_\_\_**

**E. What is your educational background? HS  Some College  College Grad  Grad School**

Have you traveled outside of the USA in the last three years? Yes  No  Where? \_\_\_\_\_

**F. Religious preference \_\_\_\_\_**

### VI. Immunizations and Preventive Medicine

**A. Immunizations**

Please give us the approximate dates of the following immunizations/vaccinations.

Vaccine	Year Given	Unknown	Never	Vaccine	Year Given	Unknown	Never
Diphtheria/Tetanus (DT)		<input type="checkbox"/>	<input type="checkbox"/>	Measles/Mumps/Rubella		<input type="checkbox"/>	<input type="checkbox"/>
Influenza		<input type="checkbox"/>	<input type="checkbox"/>	Pneumonia (pneumococcal)		<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis A		<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis B (date of last dose)		<input type="checkbox"/>	<input type="checkbox"/>
Other		<input type="checkbox"/>	<input type="checkbox"/>	Other		<input type="checkbox"/>	<input type="checkbox"/>

**B. Preventive Medicine procedures**

Please tell us the most recent time (or if) you have had the following Preventive Medicine procedures.

Procedure	Year done	Unknown	Never	Procedure	Year done	Unknown	Never
Colonoscopy (colon scope)		<input type="checkbox"/>	<input type="checkbox"/>	Sigmoidoscopy (short colon scope)		<input type="checkbox"/>	<input type="checkbox"/>
DEXA (bone calcium) back or hip (not heel or wrist)		<input type="checkbox"/>	<input type="checkbox"/>	DEXA (bone calcium) heel or wrist (not back or hip)		<input type="checkbox"/>	<input type="checkbox"/>
Stool blood check		<input type="checkbox"/>	<input type="checkbox"/>	Prostatic Specific Antigen (PSA) men only		<input type="checkbox"/>	<input type="checkbox"/>
Mammogram – women only		<input type="checkbox"/>	<input type="checkbox"/>	Pap smear – women only		<input type="checkbox"/>	<input type="checkbox"/>
Cholesterol check		<input type="checkbox"/>	<input type="checkbox"/>	Complete blood fat check (lipid panel)		<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma screen		<input type="checkbox"/>	<input type="checkbox"/>	Vision testing		<input type="checkbox"/>	<input type="checkbox"/>
TB Skin testing		<input type="checkbox"/>	<input type="checkbox"/>	Hearing testing (audiometry)		<input type="checkbox"/>	<input type="checkbox"/>
Electrocardiogram (EKG)		<input type="checkbox"/>	<input type="checkbox"/>	Stress EKG (treadmill test)		<input type="checkbox"/>	<input type="checkbox"/>
Complete physical		<input type="checkbox"/>	<input type="checkbox"/>	Breathing test (spirometry)		<input type="checkbox"/>	<input type="checkbox"/>
Body fat analysis		<input type="checkbox"/>	<input type="checkbox"/>	At home/work blood pressure monitoring		<input type="checkbox"/>	<input type="checkbox"/>