NEW PATIENT HEALTH QUESTIONAIRE

Name:_____ DOB:_____

Referring Doctor:_____ Family Doctor:_____

Why are you seeing the doctor today?_____

How long have you had this problem?_____

What improves or worsens the problem/pain?_____

Are there any symptoms that go along with the problem/pain?_____

Is the problem/pain continuous or does it come and go?_____

Describe the pain (sharp/dull, etc.)_____

Have you tried any medicine/treatment for this problem/pain?_____

Please list your preferred Pharmacy name and location: PHARMACY NAME: _____

PHARMACY LOCATION: _____

PAST MEDICAL HISTORY

Please mark (X) if you have or have had any of the following diseases or conditions:

CARDIOVASCULAR:
____Anemia
____Angina
____Aortic Aneurysm
____Arrhythmia
____Atrial fibrillation
____Bleeding Disorder
____Congestive Heart Failure
____Deep Vein Thrombosis
____Heart Attack
____Heart Disease
____Heart Murmur
____Hypertension
____Sickle Cell Anemia
____**Other**:_____

ENDOCRINE/ METABOLIC:
____Diabetes Mellitus
____Gout
____Hyperthyroidism
____Hypothyroidism
____**Other**: _____

GENERAL:
____AIDS
____HIV
____Hepatitis _____
____High Cholesterol
____Lipid disorder
____Obesity
____Sleep Apnea

GASTROINTESTINAL:
____Constipation
____Crohn's Disease
____Diarrhea
____Diverticulosis
____Acid Reflux
____Hemorrhoids
____Hiatal Hernia
____Inflammatory Bowel Disease
____Liver Disease
____Pancreatitis
____Stomach Ulcer
____**Other**:_____

GENITOURINARY:
____Benign Prostatic Hypertrophy
____Bladder Infection
____Chronic Prostatitis
____Chronic Renal Failure
____Elevated PSA
____HPV
____Kidney Disease
____Kidney Infection
____Kidney Stones
____Prostate Cancer
____Undescended Testicle
____Urinary Tract Infection
____Venereal Disease

HEENT:
____Cataracts
____Deafness
____Glaucoma
____Other: _____

MUSCULOSKELETAL:
____Arthritis
____Back Pain
____Fibromyalgia
____**Other**: _____

NEUROLOGICAL/ PSYCHOLOGICAL
____ADHD
____Alcoholism
____Alzheimer's Disease
____Anxiety Disorder
____Bi-Polar
____Chronic Fatigue Syndrome
____Depression
____Eating Disorder
____Seizure Disorder
____Herniated Disc
____Mental Illness
____Migraine
____Parkinson's Disease
____Stroke
____**Other**:_____

RESPIRATORY
____Asthma
____Bronchitis
____COPD
____Emphysema
____Pulmonary Embolism
____Tuberculosis
____**Other**:_____

TUMORS:
____Brain Tumors
____Breast Cancer
____Cervical Cancer
____Colon Cancer
____Gastric Cancer
____Laryngeal Cancer
____Lung Cancer
____Lymphoma
____Melanoma
____Pancreatic Cancer
____Rectal Cancer
____Leukemia
____**Other**:_____

SURGICAL HISTORY

Please list any surgeries you have had and date of surgery:

_____

_____

FAMILY HISTORY

Please list anything that a parent, sibling, aunt, uncle and/or grandparent has/had:

_____

_____

SOCIAL HISTORY

Please provide the following information:

Marital Status:

☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Life Partner ☐ Common Law Spouse

Occupation - Please CIRCLE the one that applies:

None Laborer Truck Driver Tradesman Clerk Administrative Executive Professional Part-Time Retired Other:_____

Alcohol Consumption:

_____None _____Yes Occasional / Social # of drinks per day_____

Tobacco per day:

_____None _____Yes #_____Packs/day _____Cigarettes/day _____Smokeless Tobacco

If you previously stopped, when? _____

Recreational Drugs: _____None If yes, please list:_____

Caffeinated beverages: _____None _____Low _____Moderate _____Excessive

ALLERGIES – Please list ALL types (Drug, seasonal, pets, environmental foods)

_____

_____

_____

REVIEW OF SYSTEMS

Please mark (X) if you have any of the following:

CONSTITUTIONAL:

____Chills
____Easily bruises
____Fever
____Fatigue
____Generalized Weakness
____Insomnia
____**Other**:_____

EYES:

____Blurred Vision
____Cataracts
____Glaucoma
____Other:_____

ALLERGIC/ IMMUNOLOGIC:

____Drug Allergies
____Environmental Allergies
____Food Allergies
____Seasonal Allergies
____**Other**:_____

NEUROLOGICAL:

____Balance problems
____Dizzy spells
____Headache
____Memory Loss
____Numbness/ Tingling
____Stroke
____**Other**:_____

ENDOCRINE:

____Tired/ Sluggish
____**Other**:_____

GASTROINTESTINAL:

____Abdominal Cramps
____Abdominal Pain
____Acid Reflux
____Bloody Stools
____Constipation
____Diarrhea
____Hemorrhoids
____Nausea/ Vomiting
____Rectal Bleeding
____**Other**:_____

CARDIOVASCULAR:

____Chest pain/ Angina
____Heart Attack
____Irregular Heart beat
____Pace Maker Implant
____Palpitations
____Swelling
____**Other**:_____

MUSCULOSKELETAL:

____Arthritis
____Back Pains
____Gout
____Muscle Weakness
____**Other**:_____

GENITOURINARY:

See HPI

RESPIRATORY:

____Frequent Cough
____Pneumonia
____Shortness of Breath
____Wheezing
____**Other**:_____

HEMATOLOGICAL/LYMPHATIC:

____Swollen Glands
____Blood Clotting Problems
____Bleeding Problems
____Hepatitis
____HIV/ AIDS
____Sickle Cell
____**Other**:_____

PSYCHOLOGICAL:

____Anxious
____Depressed
____**Other**:_____

CURRENT MEDICATIONS – **Please list ALL medications you are currently taking including over the counter medicine**

Drug Name:	Strength:	Directions/How you take it: