

PATIENT INFORMATION

NAME _____ AGE _____ SEX _____

SOCIAL SECURITY NO. _____ DATE OF BIRTH _____

HOME ADDRESS _____

CITY STATE ZIP _____ REFERRED BY _____

SINGLE [] MARRIED [] WIDOWED [] DIVORCED []

HOME PHONE _____ CELL PHONE _____

WORK PHONE _____ E-MAIL _____

OCCUPATION _____ EMPLOYER _____

WORK ADDRESS _____

CITY STATE ZIP _____

PRIMARY INSURANCE _____ **POLICY HOLDER** _____

IDENTIFICATION NO. _____ GROUP NO. _____

ADDRESS _____

CITY STATE ZIP _____ PHONE NO. _____

SECONDARY INSURANCE _____ **POLICY HOLDER** _____

IDENTIFICATION NO. _____ GROUP NO. _____

ADDRESS _____

CITY STATE ZIP _____ PHONE NO. _____

DRIVERS LIC. NO. _____ STATE _____

CREDIT CARD _____ NUMBER _____ EXPIRES _____

PERSON TO CONTACT IN EMERGENCY _____

HOME PHONE _____ WORK PHONE _____

CELL PHONE _____ RELATION TO PATIENT _____

X _____ DATE _____

SIGNATURE

NEW PATIENT MEDICAL QUESTIONNAIRE, Page 1

Name _____ **Birth Date** _____ **Sex** ____ **S M W D** **Occupation** _____

Chief complaint (Why are you here?) _____

Current prescription medications _____

OTC Medications, Vitamins, Supplements _____

Allergies to medications _____ **Any other allergies?** _____

Tobacco Use (how much, how long) _____ **Alcohol** (how much in average week) _____

Current Weight _____ **Weight one year ago** _____ **Maximum weight** _____

Current medical problems/diagnoses _____

Previous medical history _____

Hospitalizations, Surgery _____

Family history: Cancer [] Heart Disease [] Diabetes [] High Blood Pressure [] Colitis [] Emotional problems [] Early death []

Details of Family History _____

Have you ever had: Colonoscopy [] Rectal Bleeding [] Black tarry stools [] Vomiting blood [] Inflammatory Bowel Disease []

Ulcerative colitis [] Crohn's Disease [] Hemorrhoids [] Diverticulitis [] Food allergies [] Malabsorption syndrome []

Irritable bowel syndrome (IBS) [] Prolonged constipation [] Prolonged diarrhea [] Intestinal infections [] Parasites or worms []

Other bowel disease [] Stomach trouble [] Ulcers [] Hiatus hernia [] Reflux/GERD [] Excessive gas [] Gallbladder disease []

Liver disease [] Immunization for hepatitis A [] for hepatitis B [] Jaundice [] Pancreatitis [] Recent change in appetite []

Sexually transmitted diseases [] **Explain any positives:** _____

NEW PATIENT MEDICAL QUESTIONNAIRE, Page 2

Screening for preventable medical problems: Have you ever been screened for:

	Yes	No	N/A	When was the last time?
Colorectal cancer?	[]	[]		_____
Breast cancer?	[]	[]	[]	_____
Cervical cancer?	[]	[]	[]	_____
Prostate cancer?	[]	[]	[]	_____
Osteoporosis?	[]	[]	[]	_____

Social History:

	Yes	No		Yes	No	N/A		Yes	No
Do you exercise adequately?	[]	[]	Do you sleep well?	[]	[]		Do you like your work?	[]	[]
Are you sexually active?	[]	[]	Is sex satisfactory?	[]	[]	[]	Treatment for alcoholism?	[]	[]
							Treatment for drug abuse?	[]	[]

Emotional History:

		Yes	No		Yes	No		Yes	No
Are you often:	Depressed?	[]	[]	Anxious?	[]	[]	Irritable?	[]	[]
	Jumpy or jittery?	[]	[]	Unable to concentrate?	[]	[]			

Explain any pertinent details: _____

For Women Only:

Menstrual history: Age at onset _____ Usual duration of periods _____ Interval between periods _____

Are your periods regular? Y/N Date of last period _____ Are you usually: Heavy [] Medium [] Light []

Before periods, do you have: tension? Y/N depression? Y/N mood swings? Y/N. During periods, do you have cramps? Y/N pain? Y/N

Pregnancies: How many? _____ Children: _____ Caesarean sections? _____ Premature births? _____

Complications? _____

Are there any other issues you wish to discuss with the doctor today? _____

