Medical History - New Patient Questionnaire
As a new patient, you have a lot of background to share with a new physician. Complete and bring this form with you to the appointment to simplify the registration process. Keep a copy for your records so that it is available when you need to visit other doctors.

1. Is there anyone in your family with heart disease, high blood pressure, diabetes, kidney, cancer or other medical problems?  Yes ___ No ___

   Please list any conditions and how the person is related to you.
   
   Condition: ___________________________ Relationship: ___________________________
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   Condition: ___________________________ Relationship: ___________________________
   Condition: ___________________________ Relationship: ___________________________

2. List your current physicians.

   Specialty: ___________________________
   Specialty: ___________________________
   Specialty: ___________________________

3. Enter the date of your last physical exam and list the physician who saw you.

   Month: ___________________________ Date: _______ Year: _______
   Physician: ___________________________

4. (Women only) Enter the date of your last OB/GYN exam and list the physician who saw you.

   Month: ___________________________ Date: _______ Year: _______
   Physician: ___________________________

5. List any medical conditions you have and for how long you've had the condition (first month/year diagnosed)

   Condition: ___________________________ Month: _______ Year: _______
   Condition: ___________________________ Month: _______ Year: _______
   Condition: ___________________________ Month: _______ Year: _______
   Condition: ___________________________ Month: _______ Year: _______
   Condition: ___________________________ Month: _______ Year: _______
6. Have you ever gone to an emergency room for treatment in the last year? Yes ___ No ___
   How many times in the past year? ________________________________
   List the reason and when you made each ER visit.
   Reason: _____________________________ Month: _____ Year: _____
   Reason: _____________________________ Month: _____ Year: _____
   Reason: _____________________________ Month: _____ Year: _____

7. Have you ever stayed in the hospital overnight during the past year? Yes ___ No ___
   How many times in the past year? _____________________________
   List the reason and when you stayed overnight.
   Reason: _____________________________ Month: _____ Year: _____
   Reason: _____________________________ Month: _____ Year: _____
   Reason: _____________________________ Month: _____ Year: _____

8. Have you had surgery? Yes ___ No ___
   List the type of surgery or reason for surgery including dates.
   Reason: _____________________________ Month: _____ Year: _____
   Reason: _____________________________ Month: _____ Year: _____
   Reason: _____________________________ Month: _____ Year: _____

9. List any allergies you have to food or medications ____________________________
   ____________________________

10. Have you ever had an anaphylactic reaction (turning red, overall swelling, difficulty
    breathing)? Yes ___ No ___

11. Do you smoke? Yes ___ No ___
    Select which products you use, how much, and number of years used.
    Tobacco product: ______________________________
    How much: ______________________________
    Years: ______________

12. Do you drink alcohol? Yes ___ No ___
    How many of each do you drink a day?
    Beer: _____ Wine: _____ Liquor: _____

13. Do you take any recreational drugs? Yes ___ No ___
14. Are you taking any prescription drugs currently?  Yes___  No___
List drugs, dosage, and how often you take them.

Drug Name:_________________________ Dosage: _____  How often: _____
Drug Name:_________________________ Dosage: _____  How often: _____
Drug Name:_________________________ Dosage: _____  How often: _____

15. (Your Additional Question Goes Here.) ________________________________
   ________________________________
   ________________________________
   ________________________________
   ________________________________
   ________________________________