



New Patient/Update Questionnaire

(CONFIDENTIAL)

Date Completed: _____ Name: _____ SSN#: _____

Please circle any medical problems that you have now or have had:

Diabetes, high blood pressure (hypertension), asthma, allergies, depression, anxiety, thyroid problems, arthritis, HIV, migraines, anemia, high cholesterol, cancer (please specify: _____)

Please list any other medical problem not listed above that you have now or have had:

Please list any surgeries you have had and the year you had the surgery, if you know it:

Please list all medications that you take and the dosages and frequency (please include prescribed and over-the-counter medicines, including vitamins, minerals and herbs):

Please list any allergies to medications and list non-medication allergies as well:

From what country or area of the country are you? _____

What is your occupation?: _____

Do you exercise regularly? (circle) Yes No *If yes, how often and what form of exercise?* _____

Do you now smoke? (circle): Yes No *If yes, how many per day? ____ and for how many years? ____*

Did you ever smoke? (circle): Yes No *If yes, when did you quit?* _____

Do you drink alcohol? (circle): Yes No *If yes, on average, how many drinks per week?* _____

Do you drink caffeine? (circle): Yes No *If yes, on average, how many drinks per day?* _____

Do you currently use any drugs like marijuana or cocaine? (circle): Yes No *If yes, please explain to the doctor.*

Are you (circle all that apply): single, married, widowed, divorced, separated

If married, what is your spouse's name: _____

If single, widowed, divorced or separated, do you have a significant other (boyfriend/girlfriend)?: Yes No

How would you describe your sexual orientation? (circle): heterosexual (straight), homosexual (gay), bisexual, don't know, prefer to discuss in person with doctor

List the names of your children (if any): _____

Do you observe a particular religion or faith? (circle): Yes No *If yes, please name:* _____

(continued on back)



New Patient/Update Questionnaire

(CONFIDENTIAL)

Please circle any medical problems that run in your family and list which relative has the condition:

Breast cancer: _____	High blood pressure: _____	Alcoholism: _____
Colon cancer: _____	Diabetes: _____	Depression: _____
Skin cancer: _____	Thyroid problems: _____	Parkinson's: _____
Prostate cancer: _____	Heart attacks/disease: _____	Alzheimer's: _____
Lung cancer: _____	Strokes: _____	Lymphoma: _____
Leukemia: _____	High cholesterol: _____	Other: _____

For all patients over the age of 18:

Have you ever had your cholesterol level checked? (circle) Yes No If yes, when was the last time and what was the result? _____

When was your last tetanus shot or booster? : _____

Do you use your seat belt regularly?: (circle) Yes No

If you ride a motorcycle or bicycle, do you always wear a helmet? (circle) Yes No N/A

Is/are your sexual relationship/s entirely satisfactory? (circle) Yes No If no, please explain: _____

What form of contraception do you use? _____

For all patients over the age of 40:

Do you take at least a baby aspirin per day? (circle) Yes No

For all patients over the age of 50:

Have you ever had a screening test for colon or rectal cancer (like a colonoscopy, flex sig or air-contrast barium enema)? (circle) Yes No If yes, when was the last one done? _____

For WOMEN only:

When was your last menstrual period? _____

Was it normal for you? (circle) Yes No If no, please explain: _____

When was your last pap smear? _____

Have you ever had an abnormal pap smear? Yes No If yes, please explain: _____

When was your last mammogram? _____

When was the last time you had a physician or healthcare professional do a breast exam? _____

Do you do monthly self-breast exams? (circle) Yes No

How many times have you been pregnant? _____

How many pre-term babies have you delivered? _____

How many term babies have you delivered? _____

How many abortions or miscarriages have you had? _____

How many of your children are now living? _____

Do you prefer to have a woman do your pap smears, pelvic exams and breast exams? (circle) Yes No Doesn't matter

For MEN only:

When was your last prostate exam (digital rectal exam)? _____

Have you ever had the blood test, PSA done? (circle) Yes No If yes, when was the last time? _____

Do you do monthly self-testicular exams? (circle) Yes No

Do you have any particular health concerns? (circle) Yes No *If yes, please explain:*