

New Patient/Complete Physical Pre-appointment Questionnaire

Name: _____ Today's date: ____/____/____

Age: _____ Date of Birth: ____/____/____ Who referred you to us?

Previous Primary Care Provider:

Other Specialty Physicians:

To help us get the most out of today's visit, please answer the following questions:

1. What is your main purpose in coming to our office today? (If you have a new complaint, indicate how long it has been present, what it feels like, what makes it better or worse, and what you are concerned the problem might be.)

2. Do you have any other concerns? Yes (list below) No

A.)

B.)

3. What medical conditions have you been diagnosed with in the past?

Disease	Date Diagnosed	Disease	Date Diagnosed
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4. What surgeries have you had in the past?

Surgery	Date Performed	Surgery	Date Performed
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5. Have you ever been in the hospital/ER?

Hospital/ER	What were you there for	Date
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6. Do you have any drug allergies?

Yes (list below)

No

7. Please list your medications (over the counter or prescription):

None

	Name	Dose	How many times a day?
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1.

2.

3.

4.

5.

8. What do you do for a living?

9. How much tobacco do you smoke or chew per day? _____ pack/day

NOTE: It is recommended that you stop using tobacco. WE CAN HELP! Just ask your doctor or nurse.

10. How much alcohol do you drink per week? _____ drinks/week

11. How much caffeine do you consume per day? (i.e., coffee, tea, chocolate, soda)

_____ servings/day

12. What do you do for exercise?

How long (minutes/miles)? _____

How often (days/week)? _____

NOTE: Brisk walking for 30 minutes most days is associated with a 30-percent reduction in the risk of heart attacks.

13. Please list the medical problems of your blood relatives.

Grandparents:

Parents:

Brothers/Sisters:

Children:

14. Do you take aspirin on a daily basis? Yes No
15. Have you had your vision checked in the last year? Yes No
16. Are you concerned about your weight? Yes No
17. Over the past 2 weeks have you felt little interest or pleasure in doing things?
Yes No
18. Over the past 2 weeks have you felt down, depressed, or hopeless? Yes
No
19. Have you received a tetanus shot in the last 10 years? Yes No
20. When was your last Flu shot? _____ years ago Never received
21. Have you ever had a colonoscopy? Yes No
If yes, when? ___/___/_____
Where was it performed? _____

Women Only:

22. What was the date of the last day of your last menstrual period?
Date: ___/___/___ Have you gone through menopause? Yes No
If yes, when? ___/____ (month/year)
23. What method of birth control do you use?
None Condoms Already gone through menopause The pill Tubal ligation ("tubes tied")
Hysterectomy Other (specify): _____
24. When did you start having periods? _____ years
Length of average period: _____ days
Length of average cycle: _____ days
How heavy are your periods: Heavy Medium Light
25. When was your last pap smear? ___/___/___ Never done
26. When was your last mammogram? ___/___/___ Never done
27. Do you take calcium and vitamin D on a daily basis? Yes No