

Patient Name: \_\_\_\_\_ Day time phone #: \_\_\_\_\_  
 Chart #: \_\_\_\_\_ Evening phone #: \_\_\_\_\_  
 Date: \_\_\_\_\_ Emergency phone #: \_\_\_\_\_  
 Social Security #: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Welcome to our practice. As a new patient, we will discuss your health in detail. To help us in this discussion, please complete all pages of this questionnaire.

**Primary Care Doctor:** \_\_\_\_\_ **Referring Doctor:** \_\_\_\_\_  
**Reason for visit:** \_\_\_\_\_

**MEDICAL HISTORY:**

Current Medications (prescription or over-the-counter):

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Drug Allergies:** \_\_\_\_\_

Previous Major Illness/Injuries/Surgeries (Please include dates):

\_\_\_\_\_  
 \_\_\_\_\_

**Past Medical History:**

Ear/Nose/Throat	YES	NO
Diabetes	YES	NO
Hypertension	YES	NO
Skin Cancer	YES	NO
Other Cancer	YES	NO
Heart problems	YES	NO
Arthritis/Gout	YES	NO
Difficulty healing	YES	NO
Bleeding tendency	YES	NO
Venereal disease	YES	NO
Hereditary disease	YES	NO
Asthma	YES	NO
Lung problems	YES	NO
GI/Stomach	YES	NO
GV/Kidney	YES	NO
Liver	YES	NO
Endocrine	YES	NO
Metabolic	YES	NO
Orthopedic	YES	NO

**Social History:**

Marital Status: \_\_\_\_\_  
 Use of alcohol: Never Rarely Moderate Daily  
 Use of tobacco: Never Previously, but quit  
 Currently packs/day \_\_\_\_\_  
 Use of drugs: Never  
 Type/frequency: \_\_\_\_\_  
 Hobbies: \_\_\_\_\_  
 Occupation: \_\_\_\_\_

Family medical history: (If you have no information, please also state.)

	<u>Age</u>	<u>Diseases (if healthy, leave blank)</u>	<u>If deceased, cause of death</u>
Father	_____	_____	_____
Mother	_____	_____	_____
Siblings	_____	_____	_____
	_____	_____	_____
Children	_____	_____	_____
	_____	_____	_____