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NEW PATIENT QUESTIONNAIRE

DATE: _____

NAME: _____ **D.O.B.**_____**AGE**____

Sex: M F Marital Status: Single Married Divorced Widowed Other
Occupation:_____ Disabled: No, Yes---Explain_____

Please complete the attached medication form as completely as possible. Also, list all your medication allergy and the type of reactions on that form

State the approximate date of the following **screening tests**:
1. Eye exam_____ 2. EKG_____ 3. Mammogram_____

4. Bone density_____5. Colonoscopy_____ 6. Pelvic exam/Pap-smear_____

7. Prostate exam_____ 8. Foot Exam_____ 9. Blood Work_____

State the approximate date of the following **vaccinations/immunizations:**
1. Flu _____2. Pneumonia_____3. Tetanus_____

4. Shingles_____5. Hepatitis B_____6. Others_____

Blood Transfusion: No, Yes
Give Details_____

Family Member	Age	Medical History	Age at time of Death, if applicable	Cause of Death, if applicable	Comments
Father					
Mother					
Brothers or Sisters					

List all **Surgeries & Hospitalizations** (include approximate dates)**:**
_____
_____
_____

Females Only: Are you currently pregnant, planning a pregnancy, or nursing a child? **[Yes]/[No]**
Date of Last regular menstrual period_____

ALLY HEALTHCARE

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Patient Medication Sheet

Name: _____ D.O.B: _____ Date: _____

Please list all your medication allergies (use additional paper if necessary):

Name of Medication to which you are Allergic	**Type of Reaction (rash, swelling etc.)**

List all Medications you are **presently** using (use additional paper if necessary):

Name of *Medication* as spelled on prescription bottle	**Dose in mg**	**Instructions**/How often do you take it	Check if you need **Refills**

Past Medical History – Do you have or have had any of these illnesses?

- ☐ 1 Glaucoma or Cataracts
- ☐ 2 Macular degeneration
- ☐ 3 Frequent ear Infection
- ☐ 4 Hay fever? Sinus allergies
- ☐ 5 Chronic sinusitis
- ☐ 6 Asthma or Emphysema (COPD)
- ☐ 7 Chronic bronchitis
- ☐ 8 Pneumonia
- ☐ 9 Heart Murmur
- ☐ 10 High Blood Pressure
- ☐ 11 Heart attack or heart disease
- ☐ 12 Irregular heartbeat / Pacemaker
- ☐ 13 High cholesterol
- ☐ 14 Acid Reflux or GERD
- ☐ 15 Hepatitis
- ☐ 16 Peptic or Stomach Ulcers
- ☐ 17 Irritable Bowel Syndrome (IBS)
- ☐ 18 Diverticulosis or Diverticulitis
- ☐ 19 Hemorrhoids
- ☐ 20 Gall Bladder Disease
- ☐ 21 Colitis
- ☐ 22 Frequent Urine infections
- ☐ 23 Kidney Stone
- ☐ 24 Enlarged Prostate
- ☐ 25 Chronic Kidney Disease
- ☐ 26 Sexually Transmitted Disease
- ☐ 27 Diabetes or Pre-Disease
- ☐ 28 Thyroid disease
- ☐ 29 Varicose Veins/Phlebitis
- ☐ 30 Tuberculosis
- ☐ 31 Stroke
- ☐ 32 Epilepsy
- ☐ 33 Migraine headaches
- ☐ 34 Anemia
- ☐ 35 Gout
- ☐ 36 Rheumatoid Arthritis
- ☐ 37 Osteoarthritis
- ☐ 38 Lupus
- ☐ 39 Psonasis or Eczema
- ☐ 40 Anxiety or Depression
- ☐ 41 Schizophrenia
- ☐ 42 Bipolar disorder
- ☐ 43 German Measles/Rubella
- ☐ 44 Chicken Pox
- ☐ 45 Measles
- ☐ 46 Scarlet Fever
- ☐ 47 Mumps
- ☐ 48 Polio
- ☐ 49 Rheumatic fever
- ☐ 50 Cancer
  Which _____
- ☐ 51 Other _____

Review of Symptoms –Do you HAVE or RECENTLY has any of these symptoms?

- ☐ 1 Unusual fatigue or weakness
- ☐ 2 Fever or chills
- ☐ 3 Recent weight loss or gain
- ☐ 4 decreased hearing
- ☐ 5 Ringing in ear
- ☐ 6 Dizzy Spells
- ☐ 7 Earache
- ☐ 8 Failing Vision
- ☐ 9 Double or Blurred Vision
- ☐ 10 Eye pain
- ☐ 11 Eye Infection
- ☐ 12 Nose Bleeds
- ☐ 13 Sinus congestion or pain
- ☐ 14 Sore Throat
- ☐ 15 Hoarseness
- ☐ 16 Wheezing
- ☐ 17 Shortness of breath
- ☐ 18 Chronic cough
- ☐ 19 Chest Pain or tightness
- ☐ 20 Palpitations or tachycardia
- ☐ 21 Swelling of feet or legs
- ☐ 22 Fainting spells
- ☐ 23 leg pain when walking
- ☐ 24 Loss of appetite
- ☐ 25 Difficulty swallowing
- ☐ 26 Indigestion / Heartburn
- ☐ 27 Persistent nausea / Vomiting
- ☐ 28 Abdominal pain
- ☐ 29 Change in bowel habits
- ☐ 30 Diarrhea or Constipation
- ☐ 31 Bloody or Tarry Stools
- ☐ 32 Jaundice (Yellowing of skin)
- ☐ 33 Hernia
- ☐ 34 Painful urination
- ☐ 35 Blood in urine
- ☐ 36 Overnight urination – more than 2
- ☐ 37 Incontinence or dribbling of urine
- ☐ 38 Decrease in force or urination
- ☐ 39 Urethral Discharge
- ☐ 40 Bruise or bleed easily
- ☐ 41 Convulsions/Seizures
- ☐ 42 Tremor/hands shaking
- ☐ 43 Numbness/Tingling Sensation
- ☐ 44 Frequent headaches
- ☐ 45 Memory loss
- ☐ 46 Muscle weakness
- ☐ 47 Back Pain - Recurrent
- ☐ 48 Bone Fracture/Joint Injury
- ☐ 49 Joint Pain
  Which _____
- ☐ 50 Cold hands or feet
- ☐ 51 Rashes or itching
- ☐ 52 Hives
- ☐ 53 Moodiness - Excessive
- ☐ 54 Nervousness
- ☐ 55 Depression
- ☐ 56 Phobias
- ☐ 57 Other_____

Do you wear or use? ☐ Eyeglasses or contact lenses ☐ Dentures ☐ Hearing aides

Do you wear seat belts? Yes No

Do you drink alcohol? Yes No
Type _____ How many _____ How often _____

Do you drink beverages with caffeine Yes No

Do you use drugs? (Marijuana, Cocaine, Crack Etc...) Yes No

Do you smoke cigarettes? Yes No Quit Packs per day_____ How long _____

Name_____ D.O.B_____ Date_____