**NEW PATIENT QUESTIONNAIRE**

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Today’sdate: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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 ?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**2. Are you under the care of a physician?** If yes, for what condition? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**3. Are you experiencing any of the following symptoms in relation to your main concern?**

(Answer “yes” by circling the appropriate symptom.)

**Constitutional symptoms**: fever, weight loss, extreme fatigue

**Eyes**: double vision, sudden loss of vision, blurred vision

**Ears, nose, mouth and throat**: sore throat, runny nose, ear pain

**Cardiovascular**: chest pain, palpitation

**Respiratory**: cough, wheezing, shortness of breath

**Gastrointestinal**: nausea, vomiting, abdominal pain, constipation, diarrhea, blood in stools

**Genitourinary**: irregular menses, vaginal bleeding after menopause, frequent/painful urination, bloody urine, impotence

**Skin**: rash, changing mole

**Neurological**: headache, persistent weakness or numbness on one side of the body, falling

**Musculoskeletal**: joint pain, muscle weakness, stiffness, tenderness, restricted movement

**Psychiatric**: depression, anxiety, anger

**Endocrine**: excessive thirst, cold or heat intolerance, breast mass

**Hematologic**: unusual bruising or bleeding, enlarged lymph nodes

**Allergic**: hay fever

**4. Do you have any other concerns?** If yes (list below)

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**5. List any allergies to medications or substances**.

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**6. List any medications/supplement you are currently taking.**

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**7. Do you (currently) or have you had (previously) any major medical problems?** If yes (list below)

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**8. Have you had any surgeries?** If yes (list below)

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**9. Does anyone in your family have a major medical illness such as Diabete, HTN, high cholesterol, cancer or other?** If yes (list below) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**10. What do you do for exercise?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **How long** \_\_\_\_\_\_\_\_\_\_\_\_\_\_**How often?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**11. Check (X) which substance you use and how much you use**.

Caffeine\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Tocacco\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Alcohol\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Patient Signature**