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Modern Medicine with a Tender Touch

New Patient Questionnaire

Name _____ DOB _____ Date _____

Medical History (This refers to medical problems that have already been diagnosed or treated. Please explain how this is treated, such as diet, medication, surgery, etc.)

Condition	When was it diagnosed	Resolved? How was/is it treated?
Abnormal Pap smear		
Alcohol or drug problems		
Alzheimer's/ dementia		
Anemia		
Anxiety disorder		
Asthma		
Blood clot in leg (DVT)		
Blood clot in lung (PE)		
Cancer of breast		
Cancer of colon		
Cancer of prostate		
Cancer of skin, melanoma		
Cancer of skin, other		
Cancer of other		
COPD/ emphysema		
Depression		
Diabetes		
Epilepsy		
Glaucoma		
GERD/ Chronic reflux		
Gout		
Heart attack/ angina		
Herpes		
High blood pressure		
High cholesterol		
HIV/AIDS		
Irritable bowel syndrome		
Hepatitis		
Migraines		
Osteopenia/osteoporosis		
Rheumatoid Arthritis		
Stroke		
Thyroid overactive		
Thyroid underactive		
Other condition		

New Patient Questionnaire

Name _____ DOB _____ Date _____

Surgical History

Type of surgery	Date/ dates
C-section	
Hysterectomy	
Gallbladder removal	
Heart surgery	
Hernia repair	
Cataract surgery	
Knee surgery	
Hip surgery	
Back surgery	
Other surgery	

Allergies to medications

Name of medication	Type of reaction (rash, breathing problem etc)

Allergies to Food

Name of food	Type of reaction

Medication or food intolerances

Name of substance	Type of reaction (bloating, headache, fatigue, etc)

List all supplements or over the counter medications

Name of supplement	Strength	How often do you take it?	Why do you take it?

New Patient Questionnaire

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Prescription medications

Name of medication	Is it a Capsule or tablet or liquid	Strength	How often is it taken?

Family History

Family Member	If alive, DOB	If deceased, age of death
Mother		
Father		
Siblings		
Children		

Condition	Who had this
Breast cancer	
Colon Cancer	
Other cancer	
Diabetes	
High Blood pressure	
High cholesterol	
Stroke	
Heart attack	
Osteoporosis	
Thyroid over or underactive	
Other inherited conditions	

New Patient Questionnaire

Name _____ DOB _____ Date _____

Social History

Occupation _____
Main support person/people _____
What do you do for fun? _____

Habits
Smoking:
Tobacco: Non smoker _____ Former smoker _____ When did you quit? _____
How long had you smoked? _____
Current smoker: how many packs a day _____ Last time you tried to quit _____
Are you interested in quiting now? Y N In the future? Y N How long have you been smoking? _____
Marijuana: non user _____ Former user _____ Current user _____ How much / how often _____
Other marijuana use such as edibles _____ topical _____
Drinking alcohol:
Non drinker lifelong _____
Former drinker: when did you quit? _____
Current drinker: how many drinks a day or week? _____
Has anyone suggested that you cut back? _____
Other drugs:
Never _____
Current user: what do you use? _____
Do you *exercise* regularly? Y N What do you do and how often? _____
_____
What time do you go to bed? _____ What time to you wake up? _____
Do you have any sleep issues you want to discuss? _____
Diet:
How many times a day do you eat? _____
How many servings of fruit do you typically eat a day? _____
How many servings of vegetables do you typically eat a day? _____
Do you follow any specific type of diet and if so, what is it? _____
Do you have any food issues that you want to discuss? _____
_____

Other physicians/healers involved in your care (such as dermatologist, cardiologist, chiropractor, naturopath, counselor, etc.)

Name, specialty	How do they care for you

New Patient Questionnaire

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Review of Systems (Do you have frequently or have you had any of the following in the past month?)

General:
___ Fever
___ Weight loss
___ Night sweats
___ Trouble sleeping
Skin:
___ Rash
___ Change in mole
Blood:
___ Easy bruising
___ Excessive bleeding
Endocrine:
___ Cold intolerance.
___ Heat intolerance.
___ Excessive thirst
Eye:
___ Vision changes
___ Blind spots
Ears:
___ Ringing
___ Decreased hearing
Nose/Mouth:
___ Dental abscess
___ Nosebleeds
___ Nasal congestion
Neck:
___ Goiter
___ Chronic pain
Breasts:
___ Nipple discharge
___ Pain
___ Lumps
Cardiovascular:
___ Chest pain
___ Shortness of breath
___ Leg swelling
___ Palpitations
___ Exercise intolerance
Pulmonary:
___ Chronic cough
___ Wheezing
___ Pain with breathing
Digestive:
___ Heartburn.
___ Constipation.
___ Diarrhea
___ Abdominal pain.
Genitourinary:
___ Recent infection
___ Urination at night time (#__)
___ Difficulty with erections
___ Blood in urine
Skeletal:
___ Arthritis.
___ Chronic joint pain
Brain and Nerves:
___ Dizziness.
___ Specific weakness
___ Memory loss
___ Tremor.
___ Blackouts, fainting
Psychiatric:
___ Eating disorder
___ History physical abuse
___ Anxiety
___ Depression
As appropriate:
Date of last period _____
___ Irregular periods
___ Heavy bleeding
___ Painful intercourse

Health maintenance

Pneumonia vaccine: Pneumovax _____ Prevnar 13 _____
Last mammogram _____
Last colonoscopy _____
Last bone density/ DXA _____
Last chest x-ray _____
Last Pap smear _____
Last tetanus vaccine _____
Shingles vaccine _____
Childhood vaccines _____