New Patient Questionnaire

Name ____ Date ___________________

Phone# ____ Date of Birth ___________________________

Previous Primary Care Doctor ____

Pharmacy ______________________________________Phone number _____________________________

Insurance_______________________________________

***** Please advise patient to bring in medication list from pharmacy for the last 3 to 6 months *****

Med Questionnaire (circle all that apply)

Have you had or currently have

Heart Trouble

Mild Heart attack

Chest Pain

Palpitations

Shortness of breath

Heart Failure

Blood pressure problems

Asthma

Bronchitis/emphysema

Seizure disorder

Liver Problems

Thyroid Problems

Diabetes

Stroke

Kidney problems

Alzheimer's other brain disease

History of cancer

HIV + or aids

Hepatitis

Weight loss

Fever/chills

Palpitations

Cough

Heartburn

Constipation/or Diarrhea

Bloody stools

Swelling of legs

Anemia

Recurring infections

Chronic Body Pain: Location ____

Other Conditions

****

Completed by __________________________ Date_____________________

Approved_________ Denied___________ Appt. Date____________________