New Patient Questionnaire

(Please complete both sides of this form)

Name: _____ **Date:** _____

Personal History

Birthplace: _____ Date of Birth: _____

Nationality: _____ Religious Affiliation: _____

Marital / Relationship Status: _____

Employment Status / Occupation: _____

Exercise: _____ Hobbies: _____

Average Per Day: Alcohol (type): _____ Recreational Drug Use: _____

Tobacco: _____ Tea / Coffee: _____

Medications Taken Regularly

(include prescription and over-the-counter)

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Medication Allergies: _____

_____ _____

_____ _____

Immunizations

Pneumovax (pneumonia)..... ❑ Yes ❑ No Year: _____

Hepatitis A..... ❑ Yes ❑ No Year: _____

Hepatitis B ..... ❑ Yes ❑ No Year: _____

Tetanus ..... ❑ Yes ❑ No Year: _____

Polio..... ❑ Yes ❑ No Year: _____

Small Pox ..... ❑ Yes ❑ No Year: _____

Other: _____ Year: _____

X-rays / Procedures

Chest x-ray ..... Year of Last Test: _____

Mammogram ..... Year of Last Test: _____

Colonoscopy..... Year of Last Test: _____

Bone Density Scan..... Year of Last Test: _____

Prostate Exam (Men)..... Year of Last Test: _____

TB Skin Test (PPD)..... Year of Last Test: _____

Other: _____ Year of Last Test: _____

Other: _____ Year of Last Test: _____

Family History

	Present age, or age at death	If living, health (good, fair, poor); If deceased, cause of death
Father		
Mother		
Brothers / Sisters		
1.		
2.		
3.		
4.		
5.		