New Patient Questionnaire **Patient Name:**

Review of Systems

Constitutional

Fever	□ Yes □ No
Chills / Sweats	□ Yes □ No
Headaches	□ Yes □ No

Eyes

Blurred Vision	□ Yes □ No
Double Vision	□ Yes □ No

Ears/Nose/Throat/Mouth

Ear Infection	□ Yes □ No
Sore Throat	□ Yes □ No
Sinus Problems	□ Yes □ No

Respiratory

Wheezing	□ Yes □ No
CoughSore	□ Yes □ No
Short of Breath	□ Yes □ No

Cardiovascular

Chest Pain	□ Yes □ No
High Blood Pressure	□ Yes □ No

Gastrointestinal

Abdominal Pain	□ Yes □ No
Nausea / Vomiting	□ Yes □ No
Heartburn / Indigestion	□ Yes □ No
Constipation / Diarrhea	□ Yes □ No

Genitourinary

Urine Retention	□ Yes □ No
Painful Urination	□ Yes □ No
Urinary Frequency	□ Yes □ No
Sexual Dysfunction	□ Yes □ No
Flank Pain	□ Yes □ No

Skin

Skin Rash	□ Yes □ No
Boils	□ Yes □ No
Persistent Itch	□ Yes □ No

Allergies

Hay Fever	□ Yes □ No
Drug Allergies	□ Yes □ No

Musculoskeletal

Joint Pain	□ Yes □ No
Neck Pain	□ Yes □ No
Back Pain	□ Yes □ No

Hematologic / Lymphatic

Swollen Glands	□ Yes □ No
Blood Clot Problems	□ Yes □ No

Neurological

Tremors	□ Yes □ No
Dizzy Spells	□ Yes □ No
Numbness / Tingling	□ Yes □ No

Endocrine

Excessive Thirst	□ Yes □ No
Too Hot / Cold	□ Yes □ No
Tired / Sluggish	□ Yes □ No

Psychological

Are you generally satisfied with your life?	□ Yes □ No
Do you feel depressed?	□ Yes □ No
Have you considered suicide?	□ Yes □ No

Other complaints?

Past Medical History: (Patients personal history of medical illness)

High blood pressure	□ Yes □ No	Kidney Stones	□ Yes □ No
Diabetes	□ Yes □ No	Arthritis	□ Yes □ No
Kidney Disease	□ Yes □ No	Hypothryoidism	□ Yes □ No
Heart Attack	□ Yes □ No	Lupus	□ Yes □ No
Heart Failure	□ Yes □ No	Leg Swelling	□ Yes □ No
Stroke	□ Yes □ No	Cancer	□ Yes □ No
Asthma	□ Yes □ No	Migraines	□ Yes □ No
Tuberculosis	□ Yes □ No	Hepatitis B	□ Yes □ No
Ulcers	□ Yes □ No	Hepatitis C	□ Yes □ No

Additional Medical History: (Hospitalizations, Serious Illnesses, Other)

Surgical History: (Please include surgery and date)

Family History: (Family member's history of medical illnesses)

Mother's Age _____ Father's Age _____

	No History	Father	Mother	Brother	Sister	Son	Daughter	Other
Anemia	☐	☐	☐	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐	☐	☐	☐
CAD	☐	☐	☐	☐	☐	☐	☐	☐
Diabetes Mellitus	☐	☐	☐	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐	☐	☐	☐
Hyperlipidemia	☐	☐	☐	☐	☐	☐	☐	☐
Hypertension	☐	☐	☐	☐	☐	☐	☐	☐
Kidney Disease	☐	☐	☐	☐	☐	☐	☐	☐
Kidney Stones	☐	☐	☐	☐	☐	☐		☐
Stroke	☐	☐	☐	☐	☐	☐	☐	☐
Other:	☐	☐	☐	☐	☐	☐	☐	☐

Social History:

Marital Status □ Married □ Single □Divorced □Widowed

Profession_____

Personal Habits:

Smoking □ Yes □ No □ Cigarettes □ Pipe/ Cigar □ Other
Years Smoking _____ Packs per day _____ Pipes/cigars per day _____
Years quit _____

Alcohol: □ Yes □ No Cups per day _____

Exercise: □ Yes □ No How often_____

Do you use herbal medicines? □ Yes □ No How often? _____

Allergies: (Please list all medication allergies and sensitivities)