NEW PATIENT QUESTIONNAIRE

Today's Date____/____/____

Patient Name____Weight__________Height______/______Age__________

Referred by: ☐Emergency Room ☐Walk-in Clinic ☐Primary MD ____
Current Occupation:____

Allergies: ☐Latex ☐Adhesive tape ☐Nuts ☐Seasonal ☐Berries ☐Shellfish ☐Eggs ☐Dyes ☐Iodine
☐Other____
Medication Allergies: ____Reactions:____________________________

Immunizations: Last Tetanus shot (date):_________/_________/_________

Past Medical History:
Check YES or NO for any conditions that apply.

	YES	NO		YES	NO
Asthma…………	☐	☐	Backache…………	☐	☐
Bleeding/Blood Disorder…………	☐	☐	Blood Clots/DVT…………	☐	☐
Cancer/Type__________________________	☐	☐	Cardiovascular Disease …………	☐	☐
			HeartAttack…………	☐	☐
Crohn's Disease…………	☐	☐	Depression…………	☐	☐
Diabetes:			Dentures…………	☐	☐
Insulin Injection Dependent…………	☐	☐	Fibromyalgia…………	☐	☐
Non-Insulin Dependent…………	☐	☐	Gout…………	☐	☐
Hepatitis…………	☐	☐	Hypertension…………	☐	☐
Kidney Disease…………	☐	☐	Liver Disease…………	☐	☐
Migraine Headaches…………	☐	☐	Osteoporosis/Osteopenia…………	☐	☐
Osteoarthritis…………	☐	☐	Reflux Disease…………	☐	☐
Rheumatoid Arthritis…………	☐	☐	Shortness of Breath…………	☐	☐
Peptic Ulcers…………	☐	☐	Stroke…………	☐	☐
Thyroid Disease…………	☐	☐	Tuberculosis(TB)…………	☐	☐
Wear Contacts…………	☐	☐	Wear Glasses…………	☐	☐

Surgical History:
________________________________/__________________________________/________________________________
________________________________/__________________________________/________________________________
________________________________/__________________________________/________________________________

Have you ever had a complication with anesthesia: ☐YES ☐NO____

Social History: ☐ Single ☐ Married ☐ Partnered ☐ Divorced ☐ Widowed

Work/Study Status: ☐ Full time ☐Part time ☐Disabled ☐Retired ☐Other:______________________________

Exercise: ☐YES ☐NO Type:______________________________________Frequency:_________Times per week

Recreational Drug Use: ☐YES ☐ NO Type:____ ☐ Quit

Alcohol Use: ☐YES ☐NO Type:_____________________________________ ☐ Occasional use ☐ Moderate use ☐ Heavy use

Tobacco Use: ☐YES ☐NO ☐ Cigarettes: Packs per day_______ ☐Cigars ☐Chewing Tobacco ☐Quit

Medication/Dosage List:
____
____
____
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