New Patient Questionnaire

Patient's Name: ___________________________________ DOB: ______________ Age:________

Reason for visit: ____

____

Medications (Please list a copy of ALL your current medications) *Be sure to include all prescription Medications, inhalers, over-the-counter medications, vitamins, herbs and supplements.

Medication	Dosage	Times per Day

Allergies (Medications only): Yes (Please List below) [ ] No known Allergies

Past Medical History:

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Past Surgical History: (Procedure and date)

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Family Medical History: [ ] None if adopted.

Relationship to you: M/F/Sibling	Living/Deceased (Age)	Medical Condition

Do you currently smoke? [ ] Yes [ ] No   If quit, when? ________________________

How old were you when you started smoking? ____________________

How many years did you smoke? _______________ How many packs per day? _____

Do you have exposure to second hand smoke? [ ] Yes [ ] No

Do you consume alcohol? [ ] Yes [ ] No   # drinks per   [ ] Day   [ ] Week   [ ] Month

Marijuana use? [ ] Yes [ ] No   Other recreational drugs? [ ] Yes [ ] No Type: _________

Caffeine Use? (Coffee, Tea, Soda, Energy Drinks) [ ] Yes   [ ] No

If Yes to Caffeine – What kind ___________________________ How often: ___________