NEW PATIENT QUESTIONNAIRE

Your answers on this form will help your health care provider better understand your medical concerns and conditions. If you are uncomfortable with any question, do not answer it. If you cannot remember specific details, please approximate. Add any notes you think are important. ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.

Main reason for today's visit: _____

Other concerns: _____

MEDICATIONS

Please list all the medications you are taking. Include prescribed drugs and over-the-counter drugs, such as vitamins and inhalers.

	DRUG NAME	STRENGTH	FREQUENCY TAKEN
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

PAST MEDICAL HISTORY

Please check all that apply:

- ☐ Anxiety Disorder
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorder
- ☐ Blood Clots (or DVT)
- ☐ Cancer
- ☐ Coronary Artery Disease
- ☐ Claustrophobic
- ☐ Diabetes - Insulin
- ☐ Diabetes - Non-Insulin
- ☐ Dialysis
- ☐ Diverticulitis
- ☐ Fibromyalgia
- ☐ Gout
- ☐ Has Pacemaker
- ☐ Heart Attack
- ☐ Heart Murmur
- ☐ Hiatal Hernia or Reflux Disease
- ☐ HIV or AIDS
- ☐ High Cholesterol
- ☐ High Blood Pressure
- ☐ Overactive Thyroid
- ☐ Kidney Disease
- ☐ Kidney Stones
- ☐ Leg/Foot Ulcers
- ☐ Liver Disease
- ☐ Osteoporosis
- ☐ Polio
- ☐ Pulmonary Embolism
- ☐ Reflux or Ulcers
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Other

PAST SURGICAL HISTORY

	SURGERY	REASON	YEAR	HOSPITAL
1.				
1.				
3.				
4.				

SOCIAL HISTORY

Education ☐ Less than 8th grade
☐ High school
☐ 2 year college ☐ 4 year college
☐ Post graduate

Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed ☐ Domestic partner

Exercise Level
☐ None (No exercise)
☐ Occasional exercise
☐ Moderate exercise
☐ High level exercise

Caffeine ☐ None ☐ Occasional ☐ Moderate ☐ Heavy
# of cups/cans per day? ____

Alcohol Do you drink alcohol?
☐ Yes ☐ No
If so, how often?
☐ Occasionally ☐ < 3 times a week
☐ > 3 times a week
How many drinks per week? __

Tobacco Do you use tobacco?
☐ Yes ☐ No

If not currently, did you ever use tobacco? ☐ Yes ☐ No
☐ Cigarettes - ____pks./day
☐ Chew - ____/day
☐ Cigars - _____/day
☐ # of years____
Or year quit _____

Drugs Do you currently use recreational or street drugs? ☐ Yes ☐ No
If yes, list:
_____
_____

Please review and update the information below to the best of your ability.

Patient Registration

PATIENT INFORMATION -- PLEASE PRINT

Last Name:
First Name:
Middle Name:
Address:
City: State:
Zip:
Home Phone:
Work Phone:
Mobile Phone:
Sex:
Date of Birth:
Mobile Phone:( ) _____ - _____
Patient email:
Required by government mandate [although you may refuse]:
Language:
Race:
Ethnicity:
Marital Status.

Guarantor Information (to whom statements are sent)

Name:
Address:

Relationship to patient: _____
Date of Birth:

Phone: ( ) _____ - _____

Emergency Contact Information

Name:
Relationship:
Phone:

Employer information

Employer:
Address:
Phone:

Other

Patient Referred by:

Primary Care Provider:

Contact Preference: Home Phone / Work Phone / Mobile Phone / Portal / Email

Pharmacy Information:

Name:

Crossroads:

Phone:

Primary Insurance Information

Insurance Plan Name:
Last Name:
First Name:
Middle Name:
Address:
City: State: Zip:
Date of Birth: Sex (please circle): **M** or **F**
Employer Name:
Patient's relationship to policy holder:

Secondary Insurance Information

Insurance Plan Name:
Last Name:
First Name.:
Middle Name:
Address:
City: State: Zip:
Date of Birth: Sex (please circle): **M** or **F**
Employer Name:
Patient's relationship to policy holder:

To the best of my knowledge the above information is complete and accurate.

Signed_____ **Date:**_____