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:

_____
_____
_____

Past Surgical History: (Procedure and date)

_____
_____
_____

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: _____