New Patient Information Questionnaire

Name:_____ DOB:_____ Date:_____

Email:_____

Primary Care Physician(required):_____

Referring Physician(required):_____

Insurance Carrier(required):_____

Preferred Pharmacy:_____

Is it ok to leave a message? Yes_____ No_____
If so which phone number is the best number to use?_____

Please list your current medications:
Name:_____ Dose:_____
Name:_____ Dose:_____
Name:_____ Dose:_____
Name:_____ Dose:_____

Please list any allergies you may have:_____
_____

Do you smoke? Y/N For how long?_____When did you quit?_____

How much beer or alcoholic beverages do you drink daily?_____

What is your current occupation?_____

Please list any serious illnesses or hospitalizations you have had in the past:
_____
_____
_____

Please tell us about any neurological illnesses within your family:_____
_____
_____

(For office use) BP_____ Pulse_____ Height _____ Weight_____

Name:_____DOB:_____ Date:_____

Review of Systems (Please check any symptoms that apply)

Constitutional Symptoms
___Appetite Change
___Fever
___Sleep Disturbance
___Weight Loss
___Weight Gain

Skin
___Easy Bruising
___Rash
___Tick Bite(this year)

Eyes
___Double Vision
___Dry Eyes
___Glaucoma
___Episode of Visual Loss

Ear/Nose/Mouth/Throat
___Decreased sense of smell or taste
___Hearing Loss
___Hoarseness or change in voice
___Swallowing difficulty

Respiratory
___Asthma/Wheezing
___Shortness of Breath

Cardiovascular
___Chest Pain or Angina
___Fainting
___Heart Failure
___High Cholesterol
___Hypertension
___Irregular Heartbeat(palpitations)

Genitourinary
___Kidney Stones
___Loss of Bladder Control

Bones & Joints
___Arthritis
___Swollen Joints

Psychiatric
___Depression
___Hallucinations
___Anxiety
___Panic Attacks

Endocrine
___Breast Discharge
___Diabetes
___Excessive/Decreased Sweating
___Thyroid Disease

Hematologic
___Anemia
___Bleeding Disorders
___History of Blood Clots
___Past Infusions(when?)_____

Gastrointestinal
___Blood in Stool
___Constipation
___Diarrhea
___History of GI Bleeding
___Loss of Bowel Control
___Nausea or Vomiting
___Ulcer Disease

Name:_____DOB:_____ Date:_____

Please describe your pain/sensation(circle all that apply):

Aching Throbbing Sharp Dull Shooting Burning Numbness Tingling

Please rate the level of your pain on a scale of 0(no pain) to 10(worst pain)

(Circle One) 0 1 2 3 4 5 6 7 8 9 10

What are your current symptoms?_____
When did your symptoms start?_____
Where is the locations of your discomfort?_____
_____
Other symptoms?_____

Please list all physicians that you would like to receive your reports:

1. _____
2. _____
3. _____

Family Medical History/ Please put an X next to all that apply.

Mother

___ Autoimmune Disease
___ Cancer
___ Diabetes
___ Heart Disease
___ Multiple Sclerosis
___ Migraine Headaches
___ Neuropathy
___ Seizures
___ Stroke
___Living
___Deceased

Father

___ Autoimmune Disease
___ Cancer
___ Diabetes
___ Heart Disease
___ Multiple Sclerosis
___ Migraine Headaches
___ Neuropathy
___ Seizures
___ Stroke
___Living
___Deceased