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Name: _____ Date of Birth: _____

NEW PATIENT MEDICAL QUESTIONNAIRE

Current Medical Problems:

1. _____ 5. _____
2. _____ 6. _____
3. _____ 7. _____
4. _____ 8. _____

Past Medical / Surgical History:

1. _____ 5. _____
2. _____ 6. _____
3. _____ 7. _____
4. _____ 8. _____

Current Medications (include dosage):

1. _____ 5. _____
2. _____ 6. _____
3. _____ 7. _____
4. _____ 8. _____

Current Supplements/Vitamins/Herbs/Homeopathic remedies:

1. _____ 5. _____
2. _____ 6. _____
3. _____ 7. _____
4. _____ 8. _____

Allergy to Medications: ___ YES ___ NO If Yes, what? _____

Family Medical History: Medical problems

Father	___ alive	___deceased	_____
Mother	___ alive	___deceased	_____
Children	___ alive	___deceased	_____
Siblings	___ alive	___deceased	_____
Grandparents	___ alive	___deceased	_____

Patient Signature _____ Date Signed _____