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 ____

Brother/s ___ alive ___deceased ____

Sister/s ___ alive ___deceased ____

Children ___ alive ___deceased ____

Grandparents:

Father-side ___ alive ___ deceased ____

Mother-side ___ alive ___ deceased ____

Others: ___ alive ___ deceased ____