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	______________________