Annual Physical
New Patient Health Questionnaire

Date _____

Name _____**DOB** _____

What is your primary concern for today's visit?_____

Name and phone number of your pharmacy?_____

What medications are you allergic to?_____

Please list or attach the name, dosage and frequency of your present medications.

_____ _____

_____ _____

_____ _____

_____ _____

Check the following symptoms if you have had them over the past two weeks. Considered to be normal if left blank.

__ Unintended weight loss	__ Daytime sleepiness	__ Fever or chills
__ Vision changes	__ Runny nose	__ Trouble swallowing
__ Heartburn	__ Bowel changes	__ Abdominal pain
__ Chest pain	__ Leg swelling	__ Heart palpitations
__ Cough	__ Wheezing	__ Shortness of breath
__ Urinary frequency	__ Pain with urination	__ Skin changes
__ Depressed mood	__ Anxiety	__ Numbness
__ Muscle weakness	__ Joint swelling	__ Excessive thirst
__ Intolerance to heat or cold	__ Lymph node enlargement	__ Bruising/bleeding

Are you currently a smoker? _____ Have you ever been a smoker? ___
How many packs do or did you smoke per day? ___ How many years? _____
Check the appropriate marital status. ___ Single ___ Married ___ Divorced ___ Widow
What is your occupation?_____
Please check the amount of alcohol you drink daily. __None __Social __1 __2 __3+
Please check the amount of caffeine servings you use daily. __1 __2 __3 __4+
If you use recreational drugs please list what kind. _____

Please list any prior surgeries and approximate year. _____
_____
_____

Please list the approximate year you last received the following vaccinations:

Tetanus _____ Hepatitis A _____ Hepatitis B _____ MMR _____
Pneumovax ____ Influenza _____ Gardasil _____ Varicella ____
Meningitis _____ BCG ____ Shingles/Zostavax _____

Women Only

When was the first day of your last period (or year you started menopause)? _____
Date of last Pap Smear _____Year of any abnormal Pap Smear _____
Have you had a hysterectomy? ____ Do you have your ovaries? _____
What are you using for birth control? _____ Date of last mammogram? _____
How many pregnancies have you had?____ Live births?____ miscarriages? ____

Men Only

Do you wake up to urinate at night? ___ Do you have erectile dysfunction? ___
Explain any history of prostate or testicular problems? _____

Please check if you or your relative have had the following conditions.

	Patient	Mom	Dad	Sibling	Child
High blood pressure	___	___	___	___	___
Heart Disease	___	___	___	___	___
Breast Cancer	___	___	___	___	___
Colon Cancer	___	___	___	___	___
Diabetes	___	___	___	___	___
Ovarian Cancer	___	___	___	___	___
Psychiatric Disorder	___	___	___	___	___
Drug/Alcohol Abuse	___	___	___	___	___
Osteoporosis	___	___	___	___	___
High Cholesterol	___	___	___	___	___
Lung Disease	___	___	___	___	___
Blood Disorders	___	___	___	___	___
Thyroid Disorder	___	___	___	___	___
Asthma	___	___	___	___	___

Please list anything else you believe is relevant to your medical health.

_____
_____
_____