

New Patient Questionnaire

Patient Name: _____ Date of Visit: _____
Birth Date: _____ Age: _____
Pharmacy: _____ Referring Physician: _____
Primary Care Physician: _____ Child accompanied by: __ Dad __ Mom __ Other
Chief Complaint: (describe briefly) May we provide your PCP a visit summary? __ Y __ N

In the past 12 months have you experienced the following symptoms or problems? Check ALL that apply:

General/Constitutional:

- Chills
- Fatigue
- Sleep disturbance
- Weight gain
- Weight loss

Eyes:

- Redness
- Itching
- Watery
- Discharge
- Pain

ENT:

- Congestion
- Nasal itch
- Runny nose
- Sneezing
- Decreased hearing
- Decreased smell
- Ear pain
- Sinus pain
- Seasonal flare-ups
- Worse in __ Spring __ Summer
- __ Fall __ Winter

Cardiovascular:

- Shortness of breath at night
- Chest pain
- Fainting (syncope)
- Palpitations
- Leg or arm swelling (edema)

Respiratory:

- Snoring
- Asthma
- Age of diagnosis ____
- Cough
- What aggravates it _____
- Shortness of breath
- Sputum production
- Wheezing

Gastrointestinal:

- Abdominal pain
- Diarrhea
- Difficulty swallowing
- Heartburn
- Nausea
- Vomiting

Musculoskeletal:

- Arthritis
- Muscle aches
- Swollen joints
- Weakness

Skin:

- Swelling episodes
- Dry skin
- Eczema
- Hives
- Frequency _____
- Location _____
- Triggers _____
- Associated Bruising __Y __N
- Itching
- Rash

Neurologic:

- Numbness
- Dizziness
- Headaches

Psychiatric:

- ADHD
- Anxiety
- Depressed mood
- Psychiatric condition:
- Please list: _____

Endocrine:

- Diabetes
- Thyroid problems

Hematologic:

- Bruising
- Bleeding
- History of cancer

Allergy/Immunology:

- Frequent infections
- Food allergies
- Please list: _____

Patient Name: _____

DOB: _____

Current Medications:

| Name of medication | Dose | Times/day | Condition being treated |
|--------------------|-------|-----------|-------------------------|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

Medical History:

Are your immunizations up to date? Y N Are flu immunizations up to date? Y N
Have you undergone allergy testing in the past? Y N Have you been on allergy shots in the past? Y N
List any chronic medical conditions that you are aware of, or being treated for: _____

Allergies / Intolerances: (I am allergic to the following...)

| Medications | Foods | Stinging insects |
|-------------|-------|------------------|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

Surgical History:

| Year | Type of surgery | Year | Reason |
|-------|-----------------|-------|--------|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

Hospitalizations:

Family History: (Under each condition please write: father, mother, sibling, child, grandparent or extended family)

| Allergic rhinitis | Asthma | Eczema | Angioedema | Food allergy | Immune disorder | Cancer |
|-------------------|--------|--------|------------|--------------|-----------------|--------|
| _____ | _____ | _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ | _____ | _____ |

Social History:

Do you smoke/vape? Y N What type of pets do you own? _____
Have you ever smoked/vaped? Y N Marital status: _____
Does anyone in your home smoke? Y N Occupation: _____

Any additional information that you think the doctor should know about your situation?

