

NEW PATIENT QUESTIONNAIRE

Name: _____ Today's Date: _____
(Last) (First) (Middle Initial)

Date of Birth: _____ Age: _____ Occupation: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work: _____

Email Address: _____

How did you hear about us? Patient Name: _____ Other: _____

In Case of Emergency Contact: _____ Relationship: _____

Cell Phone: _____ Home Phone: _____ Work: _____

If you move forward with therapy, do you prefer to sign a paper or electronic consent? Electronic Paper

MEDICAL HISTORY

Height: _____ Weight: _____

Do you smoke? () Yes () No () Quit How much? _____ How often? _____ Age started? _____

Do you drink alcohol? () Yes () No () Quit How much? _____ How often? _____ Age started? _____

Any known drug allergies: () Yes () No If yes please explain: _____

Current Medications and dosage: _____

Nutritional/Vitamin Supplements: _____

Current Hormone Replacement Therapy: _____ Past HRT: _____

Surgeries, list all and Year: _____

Other Pertinent Information: _____

Do you have a personal history of? **Check all that apply.**

Preventative Medical Care:

() Medical Exam in the last year

High Risk Past Medical/Surgical History:

- () Breast Cancer
- () Prostate Cancer

Birth Control Method:

() Vasectomy

Medical Illnesses:

- () High blood pressure
- () Heart bypass
- () High cholesterol
- () Hypertension
- () Heart Disease
- () Stroke and/or heart attack

- () Blood clot and/or a pulmonary emboli
- () Arrhythmia
- () Any form of Hepatitis or HIV
- () Lupus or other auto immune disease
- () Fibromyalgia
- () Trouble passing urine or take Flomax or Avodart
- () Chronic liver disease (hepatitis, fatty liver, cirrhosis)
- () Diabetes
- () Thyroid disease
- () Arthritis
- () Depression/anxiety
- () Psychiatric Disorder
- () Cancer Type: _____ Year: _____

PRINT NAME

SIGNATURE

DATE