New Patient Examination Questionnaire

Patient Name: _____ DOB: _____

Reason for visit: _____ Accompanied by: _____

Referring or primary care physician: _____ **Handedness: Right ☐ Left ☐ Ambidextrous ☐**

***Provide a list of all prescription and non-prescription medications and Known Drug Allergies/Reactions on the back of this form or a separate piece of paper ***

Medical History: List all of your MEDICAL HISTORY (Use back of paper if necessary)

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Surgical History: List SURGERY HISTORY (Use back of paper if necessary)

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Review of Systems: (Please mark all that apply)

General ☐Fever ☐Chills ☐Sweats ☐Fatigue

Allergy: ☐Hay fever ☐Food allergies ☐Environmental

Dermatology: ☐Rash ☐Dryness ☐Itching

HEENT: ☐Blurred ☐Double ☐Eye Pain ☐Vision loss ☐Sensitivity to light ☐Spots ☐Hearing loss ☐Ringing in ears ☐Trouble swallowing ☐Trouble chewing ☐Drooling

Respiratory: ☐Cough ☐Wheezing ☐Shortness of breath

Cardiology: ☐Chest pain ☐Palpitations ☐Light headed ☐Dizziness ☐Spinning ☐Dizziness upon standing

GI: ☐Nausea ☐Vomiting ☐Diarrhea ☐Constipation

GU: ☐Incontinence ☐Frequency ☐Blood in urine ☐Pain upon urinating

Musculoskeletal: ☐Back pain ☐Joint pain ☐Muscle weakness ☐Muscle soreness ☐Swelling ☐Cramping ☐Stiffness ☐Stiff neck

Neurologic: ☐Weakness ☐Numbness/Tingling ☐Seizures ☐Passed out/Fainted ☐Tremors ☐Falls ☐Headaches ☐Migraines ☐Impaired speech ☐Impaired gait ☐Balance issues ☐Facial drooping ☐Loss of voluntary movement

Psychologic: ☐Depression ☐Anxiety ☐Memory issues ☐Suicidal ideation

Blood/Lymph: ☐Abnormal bruising ☐Bleeding ☐Persistent infection(s)

Endocrine: ☐Cold intolerance ☐Heat intolerance ☐Weight change > 10 lbs in last month: gain ☐ loss ☐

Family Health History: List family health issues below

Mother: Medical Issues: _____

Father: Medical Issues: _____

Siblings: Medical Issues: _____

Children: Medical Issues: _____

Social History:

Do you drink alcohol?_____Yes / No How often? ☐Daily ☐Weekly ☐Rarely How many in a sitting? _____

Do you smoke?_____Yes / No ☐Former ☐Current: Daily / occasional ☐ Tobacco: Light / Heavy E cigarettes / vape /other

Do you live? ☐Alone ☐Married ☐w/Children ☐Significant Other ☐Roommates ☐Assisted Living

Do you drink caffeine?_____Yes/ No On average how many per day?_____