

NEW PATIENT QUESTIONNAIRE

Today's Date: _____

Please take a moment to fill out this summary sheet. The information that you provide will help your physician in diagnosing and treating your medical condition. Thank you.

Patient Name: _____ Your age: _____

Please briefly state the reason for your visit today:

Please state the approximate date when the above mentioned symptoms started:

Please list all medications that you are currently taking:

Please list any drug allergies that you might have:

Please list all existing health problems (Diabetes, High Blood Pressure, Heart problems, etc.):

Please list all surgeries that you have had (appendectomy, gall bladder removal, bladder or prostate surgery, etc):

Please list all health problems that run in your family (Heart disease, Cancers):

Do you smoke now: Yes No Do you use alcoholic drinks: Yes No

If YES-> please state how much,

Have you recently had any (please circle all that apply):

- | | | |
|------------------------|-----------------------------|--------------------------|
| 1. Chest Pains | 2. Shortness of Breathing | 3. Dizziness or Fainting |
| 4. Loss of appetite | 5. Weight loss or gain | 6. Fatigue |
| 7. Fevers | 8. Chills | 9 Vomiting |
| 10. Back Pain | 11 Abdominal pain | 12. Leakage of urine |
| 13. Frequent urination | 14. Urinating at night time | 15 Straining to urinate |
| 16 Blood in Your urine | 17. Constipation | 18. Diarrhea |