Name:
DOB:
Date:

New Patient Questionnaire

Any Known Drug Allergies: _____

PreferredPharmacy: _____

Past Medical History (Please check all that apply)

( ) Anemia/Blood disorders
( ) Asthma/lung disease
( ) Autoimmune Disorders (lupus)
( ) Cancer:_____
( ) Cholelithiasis (gallstones)
( ) Diabetes Type: ____
( ) Hepatitis
( ) HIV
( ) Hyperlipidemia (high cholesterol)
( ) Hypertension (high blood pressure)
( ) Nephrolithiasis (kidney Stones)
( ) Other:_____

( ) Behavioral/Psychiatric Disorders
( ) ADHD/ADD
( ) Anxiety
( ) Bipolar
( ) Depression

Surgical History:

( ) Cholecystectomy (gallbladder removal)
( ) Hysterectomy
( ) Tonsillectomy
( ) Tubal / Vasectomy
( ) Other:_____

Family History (please list any medical conditions of immediate family members):

_____
_____
_____
_____

Please list any medications and dosage:

_____ _____
_____ _____
_____ _____