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NEW PATIENT HISTORY QUESTIONNAIRE

Name: **Today's Date:**

Date of Birth: **Place of Birth (State, Country):**

Where would you like your prescriptions sent today? Pharmacy name & location:

How did you hear about us(check): **Yellow Pages,** **Internet,** **Friend/Family, Other**

Reason For Today's Visit

PAST MEDICAL HISTORY

Have you ever been diagnosed with any of the following (check all that apply)?

Asthma	High Blood Pressure	Diabetes	Liver Disease
Heart Murmur	Heart Disease	High Cholesterol	Gout
Seizure	Irregular Heart Beat	Blood clot in leg or lung	Glaucoma
Migraine	Carotid artery stenosis	Syncope(passed out)	HIV
Tuberculosis	Kidney disorder	Seasonal allergies	Syphilis
Depression	Bipolar disorder	Arthritis	Herpes
Stroke/CVA/TIA	Anxiety	Concussion	Gonorrhea

Cancer: (list type and date diagnosed)

1. **Have you ever had a positive TB (tuberculosis), PPD or TINES test?** **Yes** **No**
2. **Have you ever had a blood transfusion?** **Yes** **No**
3. **Have you ever been admitted to the hospital?** **Yes** **No**

   If yes, for what?

Please list all medications, vitamins, herbal products and/or nutritional supplements you take

List allergies to medicines or food:

FEMALES

Last menstrual period: **# of Pregnancies:** **Last Pap:** **Last Mammogram:**

Have you ever had an abnormal Pap or Mammogram? **Yes** **No**

FAMILY HISTORY

Any family member(mom, dad, brothers, sisters, grandparents)with any of the following(please circle):

High Blood Pressure	Diabetes	High Cholesterol	Stroke
Heart attack	Seizures	TIA	Aneurysms

Sudden Death (before 45 years old?) **Yes** **No**

Cancer (who & what type?)

Do you smoke: **Yes** **No** **Drink alcohol:** **Yes** **No** **Street Drugs:** **Yes** **No**