



New Patient Questionnaire

Please complete all 5 pages, sign and date the last page.

PLEASE be sure to put your name & date of birth on each page as they may become separate before scanning.

Name _____

Date of Birth: _____

Have you ever had a blood transfusion? No Yes If Yes, when: _____

Do you have an advanced directive? Living Will Health Care Power of Attorney Yes No

Do you wear: Glasses Contacts Hearing aid

Marital status: Single Married Separated Divorced Widowed

Children # _____ Pets _____

Tobacco Usage: Yes Never No Stopped When: _____

Type: Cigarettes _____ Packs/day for # years _____ Pipe Cigar Chewing Tobacco Snuff

Use of Alcohol: No Occasionally Daily Amount? _____

Do you drink caffeine? Yes No Type? _____ Amount? _____

Substance Abuse: No Occasionally Daily Type? _____

Present Occupation: _____

If retired, what was your previous employment? _____

Are you on a special diet or supplement? No Yes What: _____ How long: _____

Do you exercise? No Yes Frequency: _____ Type: _____

Do you have a tattoo or body piercing? No Yes When: _____

Do you have any special requests due to your religious practices/culture/values? No Yes

Special Diet Blood Transfusion Other? Please list _____

Explain above: _____

Present/Previous Health Problems: (For family boxes indicate mother, father, brother, sister, children)

	Self	Family		Self	Family
Stroke			Leg/Back/Neck Pain/specify		
Diabetes/type			Hiatal Hernia		
Heart Problems/type			Convulsions/Seizures		
Arthritis			Kidney Disease		
Breathing Problems/type			Phlebitis/Blood Clots		
High Blood Pressure			Depression/Mental Illness		
Cancer/type/location			HIV/AIDS/STDs		
Hepatitis			Bleeding Problems/type		
Thyroid/type			Other		

	Age (if living)	Age at Death (if deceased)	State of Health (If not good, state reasons)	Cause of Death
Mother				
Father				
Brother(s) No. Alive _____ Deceased _____				
Sister(s) No. Alive _____ Deceased _____				
Children No. Alive _____ Deceased _____				



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SYSTEMS REVIEW

A. GENERAL

YES NO

Comments:

	YES	NO	Comments:
1. Do you worry about your health?			
2. Do you usually feel tired?			
3. Do you feel that stress is adversely affecting your health?			

B. SKIN *Have you noticed:*

Yes No

Comments

	Yes	No	Comments
1. Skin rashes or itching			
2. Growths on the skin			
3. Sores that do not heal			
4. Change in the color or size of moles			

C. EYES *Have you noticed:*

Yes No

Comments

	Yes	No	Comments
1. Blurred vision			
2. Double vision			
3. Draining or itching eyes			
4. Pain in your eyes			

D. ENT *Have you noticed:*

Yes No

Comments

	Yes	No	Comments
1. Difficulty Hearing			
2. Ringing in your ears			
3. Nasal stuffiness or drainage			
4. Frequent or severe nosebleeds			
5. Mouth sores that do not heal			
6. Recurrent sinus infection			
7. Dentures, bridges, or caps			
8. Tooth/mouth problems that make it difficult for you to eat			

E. RESPIRATORY *Have you had:*

Yes No

Comments

	Yes	No	Comments
1. Difficulty breathing			
2. To sleep on more than one pillow # _____			
3. Waking up short of breath			
4. A constant cough			
5. Coughing up blood			
6. Wheezing in your chest			
7. Exposure to tuberculosis			
8. Recurrent history of bronchitis			
9. Recurrent history of pneumonia			



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F. CARDIOVASCULAR *Have you had:* **Yes No Comments**

1. Pain/pressure in your chest, jaw, arm w/exercise			
2. Heart palpitations at rest or during exercise			
3. A previous heart murmur			
4. Swelling in your ankles			
5. Cramps/pain in legs with walking			
6. Changes in the color of your fingers or toes			
7. History of high blood pressure			
8. History of abnormal EKG			

G. MUSCULOSKELETAL *Have you had:* **Yes No Comments**

1. Pain in joints (location)			
2. Swelling in joints (location)			
3. Morning stiffness in joints			
4. Pain in joints in cold weather			
5. Pain in lower back which interferes with activity			

H. GASTROINTESTINAL *Have you had:* **Yes No Comments**

1. Any change in appetite			
2. Any weight changes recently			
3. Difficulty swallowing			
4. Abdominal or stomach pain or discomfort			
5. Food intolerances (to fatty, greasy, spicy foods)			
6. Vomiting of blood			
7. Black or tarry stools			
8. Blood in stools			
9. Diarrhea in the last 3 months			
10. Constipation on regular basis			
11. Regular use of laxatives			
12. Eat fewer than 2 meals per day			
13. On special diets or supplements			

I. NERVOUS SYSTEM *Have you had:* **Yes No Comments**

1. Frequent or severe headaches			
2. Dizziness or lightheadedness			
3. Episodes of fainting			
4. Seizures or convulsions			
5. Difficulty remembering recent events			
6. Episodes of crying			
7. An urge to commit suicide			
8. Difficulty sleeping			
9. Frequent feelings of agitation or loss of control			
10. Tingling or numbness arms/legs			
11. Trouble speaking			
12. Difficulty w/balance, coordination or weakness			



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K. Genitourinary System *Have you had:* **Yes** **No** **Comments**

	Yes	No	Comments
1. Difficulty with urination			
2. Burning or pain with urination			
3. Hesitation with urination			
4. Getting up at night to urinate more than one time			
5. Blood in urine			
6. Loss of urine with cough/sneeze			
7. Problems with sexual function			
8. (Men) Prostate gland trouble			

J. GYN (WOMEN ONLY) *Have you had:* **Yes** **No** **Comments**

	Yes	No	Comments
1. Regular monthly periods (date last period: _____)			
2. Spotting/bleeding between your periods			
3. Heavy bleeding with your periods			
4. Pain or cramping with your periods			
5. Bloating/irritability before your period			
6. Use birth control (Form: _____)			
7. Hot flashes			
8. Have you passed menopause (if yes when)			
9. Vaginal discharge			
Please describe			
10. Monthly breast self-exam			
11. Hormone therapy			
If yes, how long? _____			
Number Pregnancies _____			
Number of Children Born Alive _____			
Number of Miscarriages _____			
Number of Stillborns _____			
Number of C-sections _____			
Number of Abortions _____			
Complications with pregnancy(s) _____			

Are you interested in serious weight loss? Yes No

Completed by: _____

Relationship to Patient: _____ Date _____

Disclaimer: In this practice it is important to know that Dr. Jessica Dowe and staff are Christians. Keep in mind that comments, concerns and advice may reflect this in conversations and are in no way intended to insult, offend or disrespect any patient. Likewise, the patient's own religious preference, if known, will be respected and patient care will not be compromised.