New Patient Questionnaire

Name: ____________________________________ Marital Status: ____________ Today's Date: ________________

To help you get the most out of your visit, please answer the following questions:

Purpose for your visit?

Please indicate how long the problem has been present, what it feels like, what makes it better or worse and what you are concerned it might be.

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Are you experiencing and of the following conditions?

Please check the appropriate symptom(s),

☐ Fever	☐ Cough	☐ Palpitations	☐ Numbness	☐ Breast Mass
☐ Weight Loss	☐ Wheezing	☐ Double Vision	☐ Frequent Falling	☐ Irregular Menses
☐ Extreme Fatigue	☐ Shortness of Breath	☐ Loss of Vision	☐ Joint Pain	☐ Vaginal Bleeding
☐ Nausea	☐ Abdominal Pain	☐ Rash	☐ Muscle Weakness	☐ Chest Pain
☐ Vomiting	☐ Constipation	☐ Changing Mole	☐ Unusual Bruising/Bleeding	☐ Bloody Urine
☐ Sore Throat	☐ Diarrhea	☐ Hay Fever	☐ Enlarged Lymph Nodes	☐ Impotence
☐ Congestion	☐ Blood in Stool	☐ Headache	☐ Excessive Thirst	☐ Depression/Anxiety
☐ Ear Pain	☐ Frequent/Painful Urination	☐ Persistent Weakness	☐ Cold/Heat Intolerance	☐ Suicidal Thoughts

Please indicate any Current or Past Medical Conditions:

Medical Condition	How Long?

List any food and/or Drug Allergies?

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What Medications Do You Currently Take	*1)*
2)	*3)*
4)	*5)*
6)	*7)*

Which Pharmacy do you use Phone #:

Personal History

Date of Last Colonoscopy:	Where
Date of Last Sigmoidoscopy:	Where
Date of Last EKG	Where
Date of Last Stress Test	Where
Date of Last Eye Exam	Where
Date of Last Dental Exam	Where

Beaufort Memorial
PHYSICIAN PARTNERS

Name: ____

List any Surgeries that you have had:

Have you had any of the following immunization?		Pneumonia		Tetanus		Flu		Hep. B

Women	Last Menstrual Cycle:	# of Pregnancies:
Date of Last Mammogram:	Where	# of Miscarriages:
Date of Last Bone Density:	Where	Type of Deliveries:
Date of Las Pap Smear:	Where	Type of Birth Control:

Men	When was your last PSA	Where

Family Medical History

Father	Alive/Deceased	Age	Medical Problems	Cause of Death
Mother	Alive/Deceased	Age	Medical Problems	Cause of Death

Brother (s)	#	Alive/Deceased	Medical Problems	Cause of Death
Sister (s)	#	Alive/Deceased	Medical Problems	Cause of Death

Children	#	Boy(s)#	Girl(s)#	Any Medical Problems

Social History

Do you currently work?	What form of work do you do?		
Have you recently traveled outside of the country?	Where		
Do you Drink Alcohol?	How often?	How much?	
Have you ever used tobacco?	Type of tobacco?	How often?	How many years?
Do you currently use tobacco?			
Do you exercise?	How often?	What form of exercise?	

Please list any other health care providers you have seen in the last three (3) years.
Include name and telephone number

Name	Phone Number

Education/Learning Preferences

Preferred learning Method: (circle all that apply) Read, Write, Demonstration
Any Impairments: (circle all that apply) Hearing, Sight, Mobility
Any Barriers to learning: (circle) Yes or No If Yes please explain: ____