New Patient Questionnaire

Name: ______________________________
Date of Birth: ________________________
Today's Date: ________________________

What are you seeking help with? ____
____

List any medication allergies that you have. ____

List all the medications you are taking. Include over the counter medications, vitamins, and supplements.

1. ____________________	5. ____________________	9. ____________________
2. ____________________	6. ____________________	10. ____________________
3. ____________________	7. ____________________	11. ____________________
4. ____________________	8. ____________________	12. ____________________

List any previous medications trials for mental health symptoms. ____
____

Which pharmacy do you use? ____

Have you ever had any of these illnesses?

☐ Cancer Type: ______________	☐ Seizures	☐ Sexually transmitted diseases
☐ Heart attack	☐ Asthma	☐ Headaches or migraines
☐ Artery disease	☐ Emphysema	☐ Fibromyalgia
☐ Heart arrhythmia	☐ Obstructive sleep apnea	☐ Restless leg syndrome
☐ High blood pressure	☐ Arthritis	☐ Chronic back pain
☐ High cholesterol	☐ Allergies	☐ Other ____________________
☐ Stroke	☐ Kidney disease	________________________
☐ Diabetes	☐ Anemia	________________________
☐ Liver disease	☐ Glaucoma	________________________
☐ Ulcers	☐ Thyroid disease	________________________
☐ Heartburn or reflux	☐ Head injury	________________________

List any surgeries that you have had. ____
____

Has anyone in your family had any of the following illnesses? If so, list their relationship to you?

☐ Depression	________________	☐ Alcohol Abuse or Dependence	________________
☐ Bipolar Disorder	________________	☐ Drug Abuse or Dependence	________________
☐ Anxiety	________________	☐ Dementia or Alzheimer's Disease	________________
☐ Panic Disorder	________________	☐ Suicide	________________
☐ Post-Traumatic Stress Disorder	________________	☐ Unexplained Sudden Death	________________
☐ Obsessive Compulsive Disorder	________________	List any other mental illness in your family	
☐ ADD or ADHD	________________	☐ ________________	________________
☐ Eating Disorder	________________	☐ ________________	________________
☐ Borderline Personality Disorder	________________	☐ ________________	________________

Social History

Are you in a relationship? ☐ Yes ☐ No If yes, with a ☐Male ☐Female Are you? ☐Married ☐Divorced ☐Widowed

Are you sexually active? ☐ Yes ☐ No

Do you have any children? ☐ Yes ☐ No If yes, list their names and ages.

Name: ______________________________ Age: _____ Name: ______________________________ Age: _____

Name: ______________________________ Age: _____ Name: ______________________________ Age: _____

Name: ______________________________ Age: _____ Name: ______________________________ Age: _____

Are you employed? ☐ Yes ☐ No Current Occupation ______________________________

Are you a student? ☐ Yes ☐ No If so, where? ______________________________

How far did you go in school? ______________________________

Have you served in the military? ☐ Yes ☐ No If yes, describe service? ______________________________

Do you smoke or chew tobacco? ☐ Yes ☐ No If yes, how much per day? ______________________________

Do you drink alcohol? ☐ Yes ☐ No If yes, ☐Occasionally ☐1 drink/day ☐2-3/day ☐4+/day

Do you use any recreational drugs? ☐ Yes ☐ No If yes, list the drugs ______________________________

Do you currently have any of the following problems?

	Yes	No
General Constitutional		
Recent weight loss	☐	☐
Recent weight gain	☐	☐
Fatigue	☐	☐
Fever	☐	☐
Eyes		
Vision changes	☐	☐
Eye pain	☐	☐
Ears, nose, mouth and throat		
Runny nose	☐	☐
Ringing in ears	☐	☐
Sore throat	☐	☐
Hearing loss	☐	☐
Dry mouth	☐	☐
Cardiovascular		
Chest pain	☐	☐
Dizziness/faintness	☐	☐
Loss of consciousness	☐	☐
Respiratory		
Cough	☐	☐
Wheeze	☐	☐
Shortness of breath	☐	☐
Gastrointestinal		
Abdominal pain	☐	☐
Nausea/vomiting	☐	☐
Diarrhea	☐	☐
Constipation	☐	☐
Blood in stool	☐	☐
Genitourinary		
Painful urination	☐	☐
Loss of libido	☐	☐
Males		
Erectile dysfunction	☐	☐

	Yes	No
Females		
Pregnant	☐	☐
Nursing	☐	☐
Change in periods	☐	☐
Hot flashes	☐	☐
Menopause	☐	☐
Musculoskeletal		
Joint pain	☐	☐
Stiffness	☐	☐
Skin		
Rash	☐	☐
Neurological		
Seizures	☐	☐
Headache	☐	☐
Numbness	☐	☐
Limb weakness	☐	☐
Poor balance	☐	☐
Endocrine		
Tremor	☐	☐
Excess sweating	☐	☐
Thin hair	☐	☐
Dry skin	☐	☐
Excess thirst	☐	☐
Excess hunger	☐	☐
Frequent urination	☐	☐
Hematologic		
Excess bleeding	☐	☐
Easy bruising	☐	☐
Allergic/immunologic		
Sneezing	☐	☐
Itching	☐	☐
Hives	☐	☐

For Office Use

I have reviewed this information. Pertinent positives and negatives are documented in my note from today's visit.

M.D./ ARNP Signature ___________________________ Date ________________

☐Kimberly VerHoef ☐Todd VerHoef ☐Dana Weibel ☐Christopher Welsh ☐Ann Glick