Primary Care New Patient Questionnaire

PERSONAL INFORMATION

Full Name

Date of Birth

Gender

Select...

Address

Phone Number

Email

EMERGENCY CONTACT

Name

Phone Number

Relationship

MEDICAL HISTORY

Please list any medical conditions:

Past surgeries/hospitalizations:

Current medications (include dosages):

Allergies (medications, food, etc.):

FAMILY HISTORY

Please indicate any family history of the following (check all that apply):

- [ ]

Diabetes

- [ ]

Hypertension

- [ ]

Heart Disease

- [ ]

Cancer

- [ ]

Other

If other, please specify

SOCIAL HISTORY

Do you currently smoke or use tobacco?

Select...

Do you consume alcohol?

Select...

Do you exercise regularly?

Select...

ADDITIONAL INFORMATION

What health concerns bring you in today?

Other information you'd like your provider to know: