

INITIAL PATIENT QUESTIONNAIRE

Today's Date: ___/___/___ HT___ Wt___ SSN:___-___-___ Sex: M / F

Your Name: _____ Birth date: ___/___/___ Age: _____

Home Address: _____
Street City State Zip

Phone: Home: _____ Cell: _____ Work: _____

Marital Status: _____ Occupation: _____ Employer: _____

Emergency Contact: _____ Phone: _____

HISTORY OF CONDITION

In your own words, what problems are you having that bring you to this office?

1. _____
2. _____
3. _____
4. _____

Current Medications: _____

Current Allergies: _____

Have you ever been diagnosed with any of the following?

<input type="checkbox"/> Diabetes	<input type="checkbox"/> Asthma	<input type="checkbox"/> Depression	<input type="checkbox"/> Mumps
<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Mental Disorder	<input type="checkbox"/> Measles
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Herpes	<input type="checkbox"/> Liver Problems	<input type="checkbox"/> Chicken Pox
<input type="checkbox"/> Cancer	<input type="checkbox"/> HIV/AIDS	<input type="checkbox"/> Vascular Disease	<input type="checkbox"/> Polio

HISTORY CONTINUED

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List any surgeries you have had: _____

Have you ever been hospitalized: _____

Have you had any previous injuries/ accidents? Please list dates and treatment if any:

Do you have a family history of chronic illness? _____

Patient Signature

Date

Please do not write below this line. Proceed to the next page.

Insured's Name: _____ Relationship: _____

Insurance Company: _____

Address: _____ City: _____ ST _____ ZIP _____

Phone: _____ Ext _____ Fax: _____

Claim #: _____ Policy #: _____

Adjustor: _____ Date Called: _____

____ Group ____ Cash ____ Private ____ W/C ____ PIP ____ LOP ____ Other

Deductible: _____ Met: _____ Coverage: _____ Medpay: _____

Additional information: _____

Attorney Name: _____ Phone: _____

Address: _____

Additional

Notes: _____
