New Patient Adult Male Medical Questionnaire

Name:_____
S / M / D / W/ P_____ Children Y / N_____
Who makes medical decisions for you if you are not able to?
Name_____ Relationship_____
Occupation:_____
Hobbies/Interests:_____
Do you have a Living Will or Advanced Directives Y / N
If not are you interested in materials on how to make one? Y / N

What is the reason for your visit today?_____
_____
_____

Current & Past Medical Problems
_____
_____
_____
_____
_____
_____
_____
_____

Current Medications (name & dose)
Please include vitamins, etc.
_____
_____
_____
_____
_____
_____
_____

Allergies to medications, food or X-ray dye_____
Pharmacy Name and Location _____
Past Surgical History, Operations, and Hospitalizations (include dates)
_____
_____
_____
_____
_____

Have you had any Blood Transfusions? When?		Tetanus Shot (Date)	
Drink Alcohol x per week		Pneumonia Shot (Date)	
Smoke Packs per day Number of Years		Flu Shot (Date)	
Last Blood Work (Date)		Colonoscopy (Date)	

Review Of Systems

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(Check any you are currently experiencing or have significant history of)

Current	Past		Current	Past	
		Weight Loss			Constipation
		Weight Gain			Blood in Stool
		Fever			Diarrhea
		Chills			Frequent Urination
		Rash			Painful Urination
		Headaches			Nighttime Urination
		Eye Problems			Prostate Problems
		Allergies			Elevated PSA
		Ear Infection			Difficulty With Erection
		Sinus Infections			Loss of Libido
		Sore Throat			Hair Loss
		Shortness of breath			Too Hot/Too Cold
		Wheezing or Asthma			Joint Pain
		Cough			Anxiety/Daily Worry
		Chest Pain or Pressure			Depression
		Funny or Rapid Heartbeat			Panic Attacks
		High Blood Pressure			Obsessive/Compulsive
		Difficulty Swallowing			Mania
		Indigestion/Heartburn			Considered/Attempted Suicide
		Barrets Esophagus			Alcohol Abuse
		Nausea			Drug Abuse
					Sleep Disorder

Family History

	Living or Deceased	Age (Current or at time of death)	List All Medical Problems
Father			
Mother			
Siblings			