Family Physicians of Richardson Date: _____

New Patient Questionnaire

Name: _____ DOB: _____

What is the reason for your visit? _____

Family History

Please check all that apply; specify which family members they apply to.

O Blood Clots _____	O Bleeding Problems _____	O Diabetes _____
O Hypertension _____	O Epilepsy _____	O Cancer _____
O Eczema/Psoriasis _____	O Heart attack/Stroke _____	O Asthma _____
O Hay fever _____	O Drug/Alcohol Problems _____	O Ulcers _____
O Kidney Problems _____	O Liver Problems _____	O High Cholesterol _____

Social History

Are you married?	YES	NO	
Do you smoke? (If yes, how often & how much)	YES	NO	_____
Do you drink alcohol? (If yes, how much & how often)	YES	NO	_____
Do you drink caffeine? (If yes, how often & how much)	YES	NO	_____
Are you currently under high stress?	YES	NO	

Females Only: Are you currently pregnant, planning a pregnancy, or nursing a child? YES NO

Active Problems	Date of Onset

Inactive Problems

Family Physicians of Richardson

Date: _____

New Patient Questionnaire

Surgeries	Date of Surgery

Current Medication	Dose	Directions	Reason

Allergy	Allergy Symptoms

Immunizations	Last year received, if known	Side effects if any
Small pox		
Tetanus		
Typhoid		
Polio		
Influenza		
Pneumonia		
Rubella		
Hepatitis		

Hepatitis C risk factor *(Check all that may apply)*

- O Blood transfusion prior to 1992
- O Contact with blood/bodily fluid
- O Shared razor/toothbrush
- O IV drug use
- O Tattoos
- O Body Piercings