NEW PATIENT QUESTIONNAIRE

7240 7th Place North West Palm Beach, FL 33411	PALM BEACH COUNTY FIREFIGHTERS WELLNESS CENTER	3228 SW Martin Down Blvd Suite 33A Palm City, FL 34990

NAME:	DATE:
DATE OF BIRTH:	OCCUPATION/EMPLOYER:
REASON FOR VISIT:	

HOSPITALIZATIONS

HAVE YOU BEEN IN THE HOSPITAL OVERNIGHT? STATE THE YEAR & OPERATION/ILLNESS (EXCEPT NORMAL PREGNANCIES)

OPERATION/ILLNESS	YEAR	OPERATION/ILLNESS	YEAR

MEDICAL & FAMILY HISTORY

PLEASE √ IF YOU OR ANY BLOOD RELATIVE HAVE/HAD ANY OF THE FOLLOWING CONDITIONS:

	YOU √	REL √		YOU √	REL √	
RECENT WEIGHT LOSS	☐	☐	BOWEL PROBLEMS	☐	☐	FATHER: ☐ ALIVE ☐ DECEASED AGE: ____
MIGRAINE HEADACHES	☐	☐	LIVER DISEASE/ HEPATITIS	☐	☐	*MEDICAL CONDITIONS:*
EPILEPSY/SEIZURES	☐	☐	KIDNEY/BLADDER PROBLEM	☐	☐	
EYE DISEASE	☐	☐	NEUROLOGICAL DISORDER	☐	☐	MOTHER: ☐ ALIVE ☐ DECEASED AGE:____
HEARING DISORDER	☐	☐	ARTHRITIS	☐	☐	*MEDICAL CONDITIONS:*
RECURRENT INFECTIONS	☐	☐	OSTEOPOROSIS	☐	☐	
ANGINA/ CHEST PAIN	☐	☐	CANCER (TYPE)_____	☐	☐	SIBLINGS:
HEART ATTACK	☐	☐	BLOOD TRANSFUSION	☐	☐	
HIGH BLOOD PRESSURE	☐	☐	ANEMIA	☐	☐	DO YOU VAPE? ☐ YES ☐ NO
STROKE	☐	☐	DIABETES	☐	☐	ARE YOU A CURRENT/FORMER SMOKER?
HIGH CHOLESTEROL	☐	☐	ALCOHOL/ DRUG ABUSE	☐	☐	☐ YES ☐ NO, NEVER ☐ QUIT
HEART VALVE DISORDER	☐	☐	MENTAL ILLNESS	☐	☐	*HOW MANY PACKS PER DAY?* _____
LUNG DISEASE	☐	☐	DEPRESSION	☐	☐	*AT WHAT AGE DID YOU START?* _____
STOMACH ULCER	☐	☐	OTHER_____	☐	☐	*AT WHAT AGE DID YOU QUIT?* _____

WHEN WAS YOUR LAST…

(YEAR)

PNEUMONIA SHOT_____ DENTAL EXAM _____
TETANUS SHOT _____ EYE EXAM _____
STOOL BLOOD TEST _____ COLONOSCOPY_____
EKG(CARDIOGRAM)_____ PROSTATE EXAM _____
CHOLESTEROL TEST_____ FLU SHOT _____

DO YOU DRINK ALCOHOL? ☐ YES ☐ NO _____ *DRINKS/WK*

COFFEE/TEA/CAFFEINE? ☐ YES ☐ NO _____ *CUPS/DAY*

ILLICIT/STREET DRUGS? ☐ YES ☐ NO

DRUG ALLERGIES	REACTION

☐ I HAVE NO KNOWN DRUG ALLERGIES

WOMEN'S HEALTH

1st day of your last period? _____

Using birth control? ☐ YES ☐ NO (*type:*_____)

Number of pregnancies _____ Number of miscarriages _____
Number of births _____ Number of abortions _____

YEAR OF LAST….

PAP SMEAR _____ ☐ NORMAL ☐ ABNORMAL
BREAST EXAM _____ ☐ NORMAL ☐ ABNORMAL
MAMMOGRAM _____ ☐ NORMAL ☐ ABNORMAL

NEW PATIENT QUESTIONNAIRE

HOME MEDICATIONS *PLEASE PROVIDE A LIST OF ALL MEDICATIONS YOU TAKE AT HOME*	DOSE (MG)	TIMES/DAY

SPECIALISTS *PLEASE PROVIDE THE NAMES OF ANY SPECIALISTS YOU SEE*	SPECIALTY *(i.e. CARDIOLOGY)*	OFFICE LOCATION *(CITY, STATE)*