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New Patient Questionnaire

Please print clearly Today's Date: ____________________

Name (First)____ (Last) ____

Address _________________________________**City**____________________ **State** _______ **Zip** __________________

Social Security # _________________________ **Gender** ☐ Male ☐ Female **Date of Birth**: ____________________________

Marital Status ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated **Spouse Name** ________________________________
Language preference: ☐ English ☐Spanish ☐Other:_____________ **Ethnicity** (Italian, Polish,etc.):_________________________

Race ☐ Caucasian ☐ African American ☐ Hispanic ☐ Asian ☐ Middle-Eastern ☐ Pacific Islander ☐ Native American

Home Phone# ___________________ **Work/Cell Phone#** (please circle one) ____

Email Address: _____________________________________ **Contact Preference** (email, cell etc.) ________________________

How were you referred to Anndrea Yetter? ____

Your Occupation ___________________________Employer____

Address ____

City _______________________________________ State __________ Zip ____

Primary Care Provider: Do you have a primary care physician? ☐ Yes ☐ No

Doctor's name: ___________________________ Office Address:____

Phone #: ___________________________________ Fax #: ____

Physical Medicine **DO YOU HAVE A PACEMAKER: ☐ Yes ☐ No** **ARE YOU PREGNANT ☐ Yes ☐ No**

Medications

Date Started	Medication	Dosage
______________________	____________________________	____
______________________	____________________________	____

Allergies to Medication

Medicine	Reaction
________________________	____
________________________	____

Hospitalizations

Date	Reason
________________________	____
________________________	____

Name:____Date____________________________________

Have you had or currently have any of the following conditions?

Gastrointestinal

- ☐ Irritable Bowel Syndrome
- ☐ Inflammatory Bowel Disease
- ☐ Crohn's
- ☐ Ulcerative Colitis
- ☐ Gastritis or Peptic Ulcer Disease
- ☐ GERD (reflux)
- ☐ Celiac Disease
- ☐ Other ______________________

Cardiovascular

- ☐ Heart Attack
- ☐ Stroke
- ☐ Elevated Cholesterol
- ☐ Hypertension (high blood pressure)
- ☐ Other ______________________

Metabolic/Endocrine

- ☐ Type 1 Diabetes
- ☐ Type 2 Diabetes
- ☐ Hypoglycemia
- ☐ Metabolic Syndrome
- ☐ Hypothyroidism
- ☐ Hyperthyroidism
- ☐ Endocrine Problems
- ☐ Infertility
- ☐ Weight Gain
- ☐ Weight Loss
- ☐ Frequent Weight Fluctuations
- ☐ Bulimia
- ☐ Anorexia
- ☐ Eating Disorder (non-specific)
- ☐ Other ______________________

Cancer

- ☐ Lung Cancer
- ☐ Breast Cancer
- ☐ Colon Cancer
- ☐ Ovarian Cancer
- ☐ Prostate Cancer
- ☐ Skin Cancer
- ☐ Other ______________________

Genital and Urinary Systems

- ☐ Kidney Stones
- ☐ Gout
- ☐ Frequent Yeast Infections
- ☐ Erectile or Sexual Dysfunction

Musculoskeletal/Pain

- ☐ Osteoporosis/Osteopenia
- ☐ Scoliosis
- ☐ Muscle Pain
- ☐ Arm Numb/Tingling
- ☐ Leg Numb/Tingling
- ☐ Neck Pain
- ☐ Middle Back Pain
- ☐ Low Back Pain
- ☐ Shoulder Pain
- ☐ Elbow Pain
- ☐ Hand/Wrist Pain
- ☐ Hip Pain
- ☐ Knee Pain
- ☐ Ankle/Foot Pain
- ☐ Joint Pain ___________________
- ☐ Other ______________________

Inflammatory/Autoimmune

- ☐ Chronic Fatigue Syndrome
- ☐ Autoimmune Disease
- ☐ Rheumatoid Arthritis
- ☐ Lupus SLE
- ☐ Immune Deficiency Disease
- ☐ Poor Immune Function (Frequent Infections)
- ☐ Food Allergies
- ☐ Environmental Allergies
- ☐ Multiple Chemical Sensitivities
- ☐ Latex Allergy
- ☐ Other ______________________

Respiratory Diseases

- ☐ Asthma
- ☐ Chronic Sinusitis
- ☐ Bronchitis
- ☐ Emphysema
- ☐ Pneumonia
- ☐ Tuberculosis
- ☐ Sleep Apnea
- ☐ Other ______________________

Skin Diseases

- ☐ Eczema
- ☐ Psoriasis
- ☐ Acne
- ☐ Melanoma
- ☐ Skin Cancer: Type ___________

Neurologic/Mood

- ☐ Depression
- ☐ Anxiety
- ☐ Bipolar Disorder
- ☐ Headaches
- ☐ Migraines
- ☐ ADD/ADHD
- ☐ Memory Problems
- ☐ Parkinson's Disease
- ☐ Multiple Sclerosis
- ☐ Other Neurological Problems ____________________________

Preventative Tests and Date of Last Test

- ☐ Full Physical Exam ___________
- ☐ Bone Density ________________
- ☐ Colonoscopy ________________
- ☐ Cardiac Stress Test ___________
- ☐ EBT Heart Scan ______________
- ☐ EKG _________________________
- ☐ Hemoccult Test-stool test for blood ________________________
- ☐ MRI _________________________
- ☐ CT Scan ______________________
- ☐ Upper Endoscopy ____________
- ☐ Upper GI Series ______________
- ☐ Ultrasound __________________

Surgeries

- ☐ Appendectomy ______________
- ☐ Hysterectomy _______________
- ☐ Gall Bladder ________________
- ☐ Hernia ______________________
- ☐ Tonsillectomy _______________
- ☐ Dental Surgery ______________
- ☐ Joint Replacement Knee/Hip ____________________________
- ☐ Heart Surgery – Bypass Valve ____________________________
- ☐ Angioplasty or Stent ____________________________
- ☐ Pacemaker ____________________________
- ☐ Other ____________________________
- ☐ None

Other

- ☐ __________________________
- ☐ __________________________

Name:____Date________________________________

Family Medical History:

□ Cancer □ Diabetes □ Heart Disease □ Stroke □ Depression

□ Seizure □ Hepatitis □ Thyroid Disease □ Alcoholism □ High Blood Pressure

□ Other: ____

Your Height: ______ft. ______inches Weight: ________lbs.

Do you smoke? □ Yes □ No If no, have you quit within the past 24 months (2 years)? Yes □ No □

If you are 65 years of age or older, have you received a Pneumonia Vaccination? Yes □ No □ If yes, when? __________

If you are between the ages of 50-75, have you received appropriate screening for Colorectal Cancer, such as colonoscopy, fecal blood testing or sigmoidoscopy? Yes □ No □ If yes, when? _________________

Nutrition

Have you ever experienced any significant weight change in the past three months? Yes □ No □
If yes, please describe change
____
Do you drink alcohol? Yes □ No □ How much/when? ______________________ Do you drink caffeine every morning? Yes □ No □
Do you have food allergies, restrictions, or sensitivities? ____
____
Describe your daily energy levels: ____
Do you get noticeably irritable, light-headed, or weak if you haven't eaten in a while? Yes □ No □
Do you crave certain foods? Yes □ No □ If so, which foods and when? ______________________________________
____
Do you crave any of the following?
□ Sugar □ Meat □ Fat □ Chocolate □ Fish □ Alcohol
□ Desserts □ Milk □ Bread □ Fried foods □ Salt □ Other _________________________
Do you take any nutritional supplements or vitamins? Yes □ No □ If so, which ones? (Be specific. Attach sheets if necessary)
____
____
How is your dental health? ____
How many bowel movements do you have a day? ____
What is the color of your urine? □ Clear □ Yellow □ Dark □ Cloudy
How many hours do you sleep? ______ Do you sleep throughout the night? Yes □ No □
Rank your skin without lotion: □ Very Dry □ Dry □ Normal □ Oily □ Combination
Do you do aerobic exercise? Yes □ No □ Times/Week _________ Minutes/Session ________
Do you do strengthening exercise? Yes □ No □ Times/Week _______ Minutes/Session _______

Men: Please check all that pertain:
□ Frequent urination □ Difficulty urinating□ Difficulty with erection □ Loss of libido□ Prostate enlargement

Women Only: Menstrual Cycle

If you are between the ages of 40-69, have you received a mammogram to screen for Breast Cancer? Yes • No • When? _________
Age of first menstruation: ________ Days of Cycle (period to period): # ________Average # of days you bleed: ______
Could you be pregnant? Yes □ No □ Pregnancies: ______ Miscarriages: ______ Children's ages:__________________________
Type of Contraception: ____
Please describe your pregnancies (full-term, complications, vaginal births…): _______________________________
____
Check if you have had any of these conditions?
□PMS □Pain Between Cycles □Ovarian Cysts □Irregular periods □Endometriosis □Incontinence □D&C □Menopause
□Pain During Intercourse □Painful periods □Yeast Infections □Loss of periods □Birth control pills □Cervical Dysplasia
□Fibrocystic breasts □Frequent Urination □Difficulty Urinating