New Patient Agenda Form

Patient Name: _____ **Birth Date:** _____ **Date:** _____

1. Why are you visiting the clinic today? _____
2. Are you experiencing any pain today? Yes / No If Yes, how severe? None - 0 1 2 3 4 5 6 7 8 9 10-Severe
3. How long ago did this problem/injury occur? _____
4. How severe is the problem/injury? Mild Moderate Severe Incapacitating
5. How often does this problem occur? Constantly Daily Weekly Randomly
6. What is the status of the problem/injury? Improving No Change Worse Resolved

Constitutional		**Cardiovascular**		**Respiratory**		**Gastrointestinal**	
Fever	Yes / No	Chest Pain	Yes / No	Cough	Yes / No	Abdominal Pain	Yes / No
Fatigue	Yes / No	Irregular Heartbeat	Yes / No	Shortness of Breath	Yes / No	Vomiting	Yes / No
						Diarrhea	Yes / No

Medications

Please list all known allergies (latex, food, medications): _____

Name and location of your pharmacy: _____

Medication Name	Dosage	Frequency

History

Family history (mom, dad, brother, sister, child) cancer, heart disease, diabetes, etc: _____

Tobacco: _____ If so, how much do you use daily? _____ If former, when did you stop? _____

Alcohol Use: No Rarely Occasional Daily

Females – First day of last menstrual cycle: _____ Hysterectomy? _____

Health Maintenance Questionnaire

Have you had your FLU SHOT? Yes No When: _____ Where: _____

Have you had your PNEUMONIA SHOT? Yes No When: _____ Provider: _____

Have you had a COLONOSCOPY or SIGMOIDOSCOPY? Yes No When: _____ Provider: _____

Have you had a FECAL OCCULT STOOL TEST? Yes No When: _____ Provider: _____

Have you had a MAMMOGRAM? Yes No When: _____ Where: _____

Have you had a PAP SMEAR? Yes No When: _____ Where: _____

Are you DIABETIC? Yes No Todays Blood Sugar: _____

If so, have you had your diabetic eye exam? Yes No When: _____ Where: _____

Have you fallen in the last year? _____ If so, did the fall result in an injury? _____