

# New Patient Appointment

Patient name: \_\_\_\_\_

Name of person with you today: \_\_\_\_\_

Relationship with the person with you: \_\_\_\_\_

Today's date: \_\_\_\_\_

Name of your Family Doctor: \_\_\_\_\_

1. Do you have any medication allergies? Yes  No  if yes, please list them and the type of reaction:

\_\_\_\_\_

2. Do you have any other allergies? Please list them and the type reaction:

\_\_\_\_\_

3. Which of the following conditions do you have / have had in the past:

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> high blood pressure | <input type="checkbox"/> asthma/breathing problems | <input type="checkbox"/> brain infection   |
| <input type="checkbox"/> heart condition     | <input type="checkbox"/> angina (chest pain)       | <input type="checkbox"/> bleeding problems |
| <input type="checkbox"/> diabetes            | <input type="checkbox"/> cancer                    | <input type="checkbox"/> stroke            |
| <input type="checkbox"/> neck pain           | <input type="checkbox"/> thyroid problems          | <input type="checkbox"/> brain tumor       |
| <input type="checkbox"/> high cholesterol    | <input type="checkbox"/> back problems             | <input type="checkbox"/> car accident      |
| <input type="checkbox"/> stomach ulcers      |  | <input type="checkbox"/> tuberculosis      |

headaches, if yes, how many per month \_\_\_\_\_

seizures, if yes, how many per month \_\_\_\_\_

Other: \_\_\_\_\_

4. Have you ever had any of the following surgeries:

- |                                       |  |
|---------------------------------------|--|
| <input type="checkbox"/> gallbladder  | <input type="checkbox"/> heart bypass      |
| <input type="checkbox"/> tonsils      | <input type="checkbox"/> Caesarean section |
| <input type="checkbox"/> hysterectomy | <input type="checkbox"/> vasectomy         |
| <input type="checkbox"/> appendix     | <input type="checkbox"/> tubal ligation    |

Other: \_\_\_\_\_

5. Anything else from your medical and health past that you would like to list:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

6. Please list out all of the medications you take (including over-the-counter and herbal medications):

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7. Do you:

smoke or chew tobacco cigarettes Yes  No

vape Yes  No

marijuana in any form Yes  No

use any other inhalant? \_\_\_\_\_

8. Do you consume more than two alcoholic beverages per week?

Yes  No  If yes, how many  3 to 5  6 to 10  more than 10

9. Does any member of your family have the following medical conditions:

stroke \_\_\_\_\_

diabetes \_\_\_\_\_

heart disease \_\_\_\_\_

brain aneurysm \_\_\_\_\_

cancer \_\_\_\_\_

Parkinson's disease \_\_\_\_\_

migraines \_\_\_\_\_

multiple sclerosis \_\_\_\_\_

seizures \_\_\_\_\_

If yes, please write their relationship to you beside i.e. mother, father, sibling, grandparent, aunt/uncle.

10. What is the **Primary Concern** that you would like to address today with Dr. Makus?

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