New Patient Questionnaire

Patient Information

Personal Information	
Full Name	
Date of Birth	
Gender	
Address	
Phone Number	
Email Address	
Emergency Contact	
Insurance Information	

Health Information

Medical History	
Current Medications	
Allergies	
Previous Surgeries	
Chronic Conditions	
Family Medical History	
Immunization History	
Lifestyle Habits (e.g., diet, exercise)	

Present Symptoms

Symptom	Duration	Severity (1-10)
Fever		
Fatigue		
Pain (specify location)		
Respiratory Issues		
Digestive Issues		
Cardiovascular Issues		
Neurological Issues		

Lifestyle Habits

Habit	Frequency	Duration
Exercise		
Diet (specify)		
Sleep Patterns		
Stress Management		
Substance Use (e.g., smoking, alcohol)		

Physician’s Signature:

Attending Physician: **Date:**