anwan
REGENERATIVE CENTER

NEW PATIENT QUESTIONNAIRE

PATIENT INFORMATION & HEALTH HISTORY

Personal Information

Name: _____ Date of Birth: _____

What Is Your Primary Language? _____

What Is Your Marital Status? ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Do you have special needs in any of the following areas?

☐ Reading ☐ Vision ☐ Hearing ☐ Mobility ☐ Other: _____

Insurance Information

I understand that my insurance will be billed in addition to my concierge fee for my office visit and procedures.

******* ALL LABWORK WILL BE BILLED TO MY INSURANCE ******* **Please Initial Here: _____**

Please Indicate Primary Insurance: _____

Subscriber's Name: _____ Subscriber's S.S. No: ___-___-_____ Date of Birth: _____

Group No. _____ Policy No. _____ Co-Payment: _____

Patients Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Other: _____

Please Indicate Secondary Insurance (If Applicable): _____

Subscriber's Name: _____ Subscriber's S.S. No: ___-___-_____ Date of Birth: _____

Group No. _____ Policy No. _____ Co-Payment: _____

Patients Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Other: _____

Preferred Pharmacy

Name of Pharmacy: _____ Address: _____

Phone No. _____ Fax No. _____

Emergency Contact

Name of Emergency Contact: _____ Relationship to Patient: _____

Home Phone No. _____ Mobile Phone No. _____

Allergies

List medication allergies and the type of allergies you had. ☐ I have no drug allergies

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Medications

List with doses. Include contraceptions, vitamins, supplements, etc. ☐ None

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Attach List If Needed

Name: _____

Your Medical Conditions (Check All That Apply)

- ☐ Allergies
- ☐ Anemia
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Blood Transfusion
- ☐ Cancer
- ☐ Clotting Disorder
- ☐ Congestive Heart Failure
- ☐ Depression
- ☐ Diabetes Mellitus
- ☐ Emphysema/COPD
- ☐ Gastroesophageal Reflux Disease (GERD)
- ☐ Glaucoma
- ☐ Heart Murmur
- ☐ HIV / AIDS
- ☐ High Cholesterol
- ☐ Hypertension / High Blood Pressure
- ☐ Kidney Disease
- ☐ Myocardial Infarction
- ☐ Nerve / Muscle Disease
- ☐ Osteoporosis
- ☐ Seizures
- ☐ Sickle Cell Anemia
- ☐ Substance Abuse
- ☐ Thyroid Disease
- ☐ Tuberculosis

Surgical History (Check All That Apply)

- ☐ Appendectomy
- ☐ Brain surgery
- ☐ Breast surgery
- ☐ CABG
- ☐ Cholecystectomy
- ☐ Colon surgery
- ☐ Tonsillectomy
- ☐ Appendectomy
- ☐ Thyroid surgery
- ☐ Lung surgery
- ☐ C-section
- ☐ Eye surgery
- ☐ Fracture surgery
- ☐ Hernia repair
- ☐ Hysterectomy
- ☐ Joint surgery
- ☐ Bunionectomy
- ☐ Varicose vein surgery
- ☐ Prostate surgery
- ☐ Weight reduction surgery
- ☐ Small intestine surgery
- ☐ Spine surgery
- ☐ Tubal ligation
- ☐ Valve replacement
- ☐ Vasectomy
- ☐ Vascular surgery
- ☐ Cardiac stent
- ☐ Bladder surgery

Have you ever had a blood transfusion? ☐ No ☐ Yes, approximate dates: _____

Family History (Check All That Apply)

	Alcohol Abuse	Breast Cancer	Ovarian Cancer	Prostate Cancer	Other Cancer(s)	Diabetes	Heart Disease	High Cholesterol	Hypertension	Mental Illness
Mother										
Father										
Sister										
Brother										
Daughter										
Son										
Other										

Other Family History: _____

Habits And Activities

Do you use tobacco? ☐ No ☐ Yes, what form? _____ How much? _____ For how long? _____
☐ In the past How many years ago did you quit? _____
Have you tried to quit? ☐ No ☐ Yes Would you like to quit? ☐ No ☐ Yes
Do you drink alcohol? ☐ No ☐ In the past ☐ Yes, how many drinks per week? _____
Do you, or have you ever used recreational drugs? ☐ No ☐ Yes, describe: _____
Do you get regular exercise? ☐ No ☐ Yes, what kind of exercise? _____
How often? ☐ Daily ☐ Weekly ☐ Monthly
List any hobbies or leisure activities: _____

Name: _____

Immunizations

Vaccination	Approximate Date	Never
Pneumonia (Pneumovax)	_____	☐
Tetanus Booster (Tdap)	_____	☐
TB Skin Test (PPD)	_____	☐
Hepatitis B Vaccine	_____	☐
Hepatitis A Vaccine	_____	☐
Varicella (Chicken Pox)	_____	☐
Shingles (Zostavax)	_____	☐

Preventive Care

Test or Procedure	Approximate Date	Never
Colonoscopy	_____	☐
Bone Density Test (DXA)	_____	☐
Cholesterol Test	_____	☐
PSA (Prostate Cancer Test)	_____	☐
Pap Smear	_____	☐
Mammogram	_____	☐
HIV Test	_____	☐

List Any Abnormal Screening Test Results (e.g. polyps, breast biopsies, etc.): _____

_____

_____

Sexual History

My sexual partners have been: ☐ Male ☐ Female ☐ Female ☐ Never Sexually Active
Have you had more than one sexual partner in the last year? ☐ No ☐ Yes
Have you ever had a sexually transmitted disease? ☐ No ☐ Yes, what and when? _____

_____

Gynecological And Obstetric History

How many times have you been pregnant? _____
Live Births? _____ Miscarriages? _____ Abortions? _____
Do you use contraception? ☐ No ☐ Yes, what kind? _____
What was your age at first menses? _____
Menstrual Periods: ☐ Regular ☐ Irregular ☐ Menopausal
Age at menopause? _____
Do you have hot flashes or other symptoms? (Specify) _____
Any gynecological conditions or problems? _____

Name: _____

Other Health Issues

Do you feel unsafe, or have you been harmed in a physical, emotional, or sexual manner, in any relationship or recent encounter? ☐ No ☐ Yes, please describe: _____

_____

_____

In the past year, have you had two weeks or more during which you felt sad, blue, or depressed? Or, have you experienced loss of interest or pleasure in things you usually cared about or enjoyed?
☐ No ☐ Yes, please describe: _____

_____

_____

In the past year, have you had any major life changes or stresses that you feel impacted your overall health?
☐ No ☐ Yes, please describe: _____

_____

_____

Additional Comments or Concerns

_____

_____

_____

_____

_____

_____

_____

_____

☐ I certify that all of the information I have provided within this document is accurate and up to date information

_____ _____ _____

Print Name **Sign Name** **Date**