

## LYNN M. SIKORSKI, D.O., P.C. NEW PATIENT QUESTIONNAIRE

NAME:	DATE:
BIRTH DATE:	SOCIAL SECURITY NUMBER:

Please mark any of the following you have had in the past or currently have:

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Diabetes (Sugar)<br><input type="checkbox"/> High Cholesterol<br><input type="checkbox"/> Thyroid Disease<br><br><input type="checkbox"/> High Blood Pressure<br><input type="checkbox"/> Heart Attack<br><input type="checkbox"/> Angina/Chest Pain<br><input type="checkbox"/> Congestive Heart Failure<br><input type="checkbox"/> Other Heart Disease<br><br><input type="checkbox"/> Hiatal Hernia<br><input type="checkbox"/> Liver Disease<br><input type="checkbox"/> Stomach Ulcers<br><input type="checkbox"/> Disease of the Colon<br><input type="checkbox"/> Hemorrhoids<br><br><input type="checkbox"/> Tobacco Use<br>How Much? _____<br><input type="checkbox"/> Alcohol Use<br>How Much? _____<br><input type="checkbox"/> IV Drug Abuse<br><input type="checkbox"/> HIV Testing<br>Results _____ | <input type="checkbox"/> Kidney Disease<br><input type="checkbox"/> Bladder Problems<br><input type="checkbox"/> Prostate Problems<br><br><input type="checkbox"/> Asthma<br><input type="checkbox"/> Chronic Bronchitis<br><input type="checkbox"/> Emphysema<br><input type="checkbox"/> Allergies<br><input type="checkbox"/> Pneumonia<br><input type="checkbox"/> Other Lung Disease<br><input type="checkbox"/> History of Exposure to TB<br><input type="checkbox"/> Headache<br><input type="checkbox"/> Stroke<br><input type="checkbox"/> Seizures/Epilepsy<br><input type="checkbox"/> Accidents/Broken Bones<br><input type="checkbox"/> Head Injury<br><input type="checkbox"/> Fainting<br><input type="checkbox"/> Reactions to Local Anesthetics<br><input type="checkbox"/> Abnormal Skin Healing<br><input type="checkbox"/> Reactions to Substances<br>Applied to the Skin<br><input type="checkbox"/> Cosmetic Surgery<br>What Type? _____ | <input type="checkbox"/> Depression<br><input type="checkbox"/> Anxiety<br><input type="checkbox"/> Psychiatric Illness<br><br><input type="checkbox"/> Arthritis<br><input type="checkbox"/> Osteoporosis<br><input type="checkbox"/> Gout<br><input type="checkbox"/> Back Problems<br><input type="checkbox"/> Eye Problems<br><input type="checkbox"/> Ear Problems<br><input type="checkbox"/> Muscle Weakness<br><input type="checkbox"/> Blood Transfusions<br><input type="checkbox"/> Bleeding/Clotting Disorder<br><input type="checkbox"/> Anemia<br><input type="checkbox"/> Cancer (Specify _____)<br><input type="checkbox"/> Other (Specify _____) |
|---|--|---|

**FOR WOMEN ONLY:**

- Date of Last Period \_\_\_\_\_  
 Could You Be Pregnant? \_\_\_\_\_  
 Abnormal Periods  
 Excessive/Male  
     Pattern Hair Growth

What are your current or past medical problems? \_\_\_\_\_

Any family history of skin cancer or other cancer? If yes, Please describe: \_\_\_\_\_

Name and address of local family doctor \_\_\_\_\_

Dentist \_\_\_\_\_

Please list the medicines you are now taking (include birth control pills, vitamins, herbal supplemer

_____	How long? _____	_____	How long? _____
_____	How long? _____	_____	How long? _____

Allergies to Medicines: YES \_\_\_\_\_ NO \_\_\_\_\_ If yes, please list \_\_\_\_\_

Previous surgeries or hospital admissions (Date, Reasons)

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