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New Patient Questionnaire

Date of this visit: _____ Referring Physician: _____

Patient Name: _____ DOB: _____ Age: _____

Please describe the problem(s) for which you are here today: _____

If injury, where did it occur? (circle one) Home School Auto Work Other _____

Date of Injury or date symptoms first appeared: _____ Ht: _____ Wt: _____

Describe the type of pain you are having: (circle all that apply) Sharp Aching Stabbing Dull

Cramping Throbbing Burning Constant Pins & Needles Comes & Goes

On a scale of 1-10 how severe is the pain (1=no pain, 10=worst pain) _____

What makes the pain worse? _____

What makes the pain better? _____

REVIEW OF SYSTEMS

What medical problems do **you** have? (circle all that apply)

Childhood Disease	Peptic Ulcers	Diabetes	Bleeding Problems
Tuberculosis	High Blood Pressure	Colitis	Heart Problems
Psychiatric Problems	Asthma	Kidney Problems	Arthritis
Alcoholism	Blood Clots	Hepatitis	Other: _____

Please list any other medical problems not listed above: _____

Females: Are you pregnant? YES NO Last menstrual period: _____

THIS BOX FOR OFFICE USE ONLY

