Leslie Brocchini, MD
Wellness Medicine

New Patient Questionnaire

Name: Date:

Main complaints today:

1. Most important problem:

    a. What treatments have been recommended for this so far?

    b. Success obtained with those treatments?

2. Second most important problem:

    a. What treatments have been recommended for this so far?

    b. Success obtained with those treatments?

Primary health and wellness goals:

Allergies to food or medicine? Yes or No If yes, please describe:

What **Medications** (Not supplements) are you taking now including over the counter drugs?

Name of Medication and Strength	AM/NOON/PM	Date Started	Take regularly as prescribed?

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List All **Vitamins, minerals, and other nutritional supplements** you are taking now. If you need more space, please list in a separate sheet. You may also bring copies of the supplement container labels to be more accurate and complete.

Vitamin/Mineral/Supplement Name, Strength and Brand	AM/NOON/PM	Date Started	Take routinely, miss any doses?

Medical and Surgical History (circle and describe, if applicable):

ILLNESS	DATE	ILLNESS	DATE
Arthritis, Location?		Thyroid disease	
Asthma/Allergies		High Cholesterol	
Cancers, Type?		Sleep Apnea	
Gastrointestinal issues ? Describe		Stroke or TIA's or Seizures	
Depression, Anxiety, or Bipolar disorder, Suicide attempts?		Infections, Type?	
Heartburn/Ulcers		Diabetes	
Heart Problems		Other: Describe	

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Any Hospitalizations or operations? Please list and date

Last blood work? What was tested and Location?

Diagnostic studies: Please list procedure and date it was completed

Bone Density? Colonoscopy?

Mammogram? Heart tests?

Family Medical History:

Illness	Family Member	Illness	Family Member
Breast Cancer		Heart disease	
Colon Cancer		Depression/Anxiety/Bipolar	
Arthritis		Alcohol or drug abuse	
Diabetes		Other?	

Female History:

Age of first Period:_____ Number of Pregnancies:_____ Date of Last Pap:_____
Age of last Period:_____ Any Abortions, Miscarriages?:_____
Are you in Menopause?:____ If yes, When did your periods stop?

Do you still have your uterus and ovaries?:____ If not, When was removal?:___Why?:____
Do you currently use contraception?:____ Type?:_____

Do you experience any of the following (circle all that apply):

Hot flashes **Night Sweats** **Vaginal Dryness** **Emotional Upheavals**
Insomnia **Anxiety** **Low Sex Drive** **Mental Fog**
Fatigue **PMS** **Water retention**

Do you take Hormones?(circle)
Estrogen Progesterone Testosterone

If you used to take and are no longer taking, when did you stop? How long were you on Hormones?

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Substance Abuse:

Caffeine	Cigarettes	Alcohol	Other recreational drugs
Cups of coffee/Tea/ Soda/Energy drinks per day?	Age started smoking?	Drinks per week?	Age started?
Size of cup?	Years smoked?	Preferred drink?	Intravenous use?
Need for energy or is it a Ritual?	Packs per day?	History of abuse?	History of abuse?

Sleep habits: regular? how many hours per night?

Do you get restful sleep?

Do you have regular routine for sleep? How do you prepare for sleep?

Dietary Information:
Please check mark next to the food/drink that applies to your current diet. Please bring a 3-day food diary to your first appointment.

USUAL BREAKFAST	USUAL LUNCH	USUAL DINNER	DESSERT
Eggs	Leftovers	Leftovers	Cookies
Oatmeal	Sandwich	Meat	Cakes
Yogurt	Salad	Beans	Fruits
Bacon/Ham	Salad dressing	Rice/Potatoes	Ice Creams
Toast/bagel	Yogurt	Pasta	Diet Sodas
Coffee/Tea	Cheese	Vegetables	
Juice/Milk	Deli Meats	Coffee	
Fruit	Cookies	Cookies	
Nuts	Fruit/Nuts	Fruit/Nuts	
None/Skip	None/Skip	None/Skip	

How many times per week do you eat out in a restaurant or fast food establishment (Mcdonalds, Burger King, etc)?

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Dietary Continued….
How many Sodas do you drink per day?

Do you have any dietary restrictions such as lactose intolerance or gluten sensitivity or vegetarian?

Exercise? How often? What activity? Do you break a sweat?

What mind-body practice do you have? (Yoga, meditation, prayer)? How often?

Rate your stress level on scale of 1-10 with 10 being the highest.

What are the top two sources of stress in your life?

Rate your overall Energy level between 0% and 100%:_____

What major decisions or changes in your life are your facing?

Describe any major losses experienced in the past 3 years.

Have you had any emotional trauma? If yes, please describe.

Have you had any physical trauma? If yes, please describe. Have you been a victim of domestic violence?

Was your childhood happy or troubled? If troubled, please describe.

*Note: If you don't feel comfortable writing about this, please consider talking to Dr. Brocchini at your appointment. Sometimes unhappy childhood events may have an impact on how the body handles stress, injury, or illness as an adult.

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Do you attend counseling/psychotherapy? If yes, Who is your counselor? How often?

Did you have many antibiotics as a child or teen for acne? Do you have silver fillings? Do you have any history of being exposed to environmental toxins?

What is your major source of water?

Do you have a history of brain injury, concussions or traumatic brain injury?

What do you do for pleasure? (Hobbies)

Relationships:
Who do you live with?

What are ages of your children?

Who are the most important people in your life?

What brings meaning and purpose to your life?

What is the attitude of those close to you about your health issues (Circle one)

Supportive **Somewhat Supportive** **Not Supportive**

Education and Occupation:
What is your level of education? completed:_____
Employed?:____
Current Occupation:_____
Describe Volunteer activities:

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