BECKFORD MEDICAL CENTER
NEW PATIENT MEDICAL QUESTIONNAIRE

Preferred Clinic Site: ____**Henderson** ____**Warrenton** ____**Centerville**

Patient's Name: ____ **Date of Visit:** ____________________

Gender: M___ F___ **Date of Birth: _____/_____/_____** **Age: _____** **Marital Status: S/M/W/D _____**

Ethnicity: __Asian __Black __Caucasian __Hispanic __Non-Hispanic __Other: __________________________

List YOUR CURRENT & PAST MEDICAL or PSYCHOLOGICAL HISTORY (i.e., Asthma, Stroke, Heart Attack, Diabetes, Diabetes, Cancer, Ulcer, Anxiety, Panic Attacks, Depression, etc.)		

List YOUR CURRENT & PAST SURGICAL HISTORY (i.e., C-section, Appendectomy, Gall Bladder Surgery, etc.)	

List any FAMILY Medical or Psychological History	
Father: ___Living, Age:____	**__Deceased, Age @ death:_____ Cause:___________________________________**
Mother: ___Living, Age:___	**__Deceased, Age @ death:_____ Cause:___________________________________**
Siblings: #Living:____ #Deceased:____ Cause:____	
List any other illnesses in your family (*example: diabetes, heart disease, stroke, breast cancer, colon cancer, etc.*)	
Family Member	**Illness**

SCREENINGS & DATE Last Done		
Pap Smear:	Mammogram:	Bone Density:
PSA:	Colonoscopy:	STD & HIV:
Stress Test:	Echocardiogram:	Other:

NOTE: ALL ACCOUNTS & FEES ARE DUE ON THE DAY OF SERVICE UNLESS OTHER ARRANGEMENTS ARE MADE IN ADVANCE.

BECKFORD MEDICAL CENTER
NEW PATIENT MEDICAL QUESTIONNAIRE

Preferred Clinic Site: ____Henderson ____Warrenton ____Centerville

Patient's Name: ____ Date of Visit: ____________________

DO YOU HAVE ANY MEDICATION ALLERGIES?	
MEDICATION	**REACTION**

Do you have any other allergies? (such as Latex, adhesives, food, dyes, etc.) ____

DO YOU TAKE ANY MEDICATIONS? (Prescription, Over-The-Counter, Herbal Supplements, etc.)		
MEDICATION	**DOSE/STRENGTH**	**HOW ARE YOU TAKING IT?**

Are you up to date with your Immunizations (shots)? Y ___ N ___
If not done in this office, please provide copy of record or office so we may have it on file: _____________________

SOCIAL HISTORY	
Smoke: __Yes __No	___ # pack/day ____# of years. When did you stop smoking?______________________
Alcohol: __Yes __No	How much? _____________ How often? ____________________________________
Exercise: __Yes __No	What & How frequently? ____
Illicit substance use/abuse? __Yes __No Type: ____	
Routinely wear seatbelts? __Yes __No	Routinely wear helmets? __Yes __No __N/A
Do you live with? __Spouse/Partner __Children __Parents __Extended Family __Other: _________________________	
Do you have weapon/s in your home? __Yes __No	Do you feel safe at home? __Yes __No
Have you ever been emotionally or physically abused by your partner or someone close/important to you?__Yes __No: ____	

NOTE: ALL ACCOUNTS & FEES ARE DUE ON THE DAY OF SERVICE UNLESS OTHER ARRANGEMENTS ARE MADE IN ADVANCE.

BECKFORD MEDICAL CENTER
NEW PATIENT MEDICAL QUESTIONNAIRE

Preferred Clinic Site: ____Henderson ____Warrenton ____Centerville

Patient's Name: ______________________________ Date of Visit: ____________________

REVIEW OF SYSTEMS (*Please check any of the following symptoms that you have recently experienced or are a concern to you*)		
General	__recent weight loss __recent weight gain __fatigue __fever __changes in appetite	
Skin	__rashes __lumps __itching __dryness __color change __hair or nail change	
Head	__headaches __head injuries __dizziness __seizures __passing out	
Eyes	Date of last exam: ___________	__glass __contacts __pain __double vision __blurring __redness __cataracts __glaucoma
Nose	__frequent colds __nasal stuffiness __nosebleeds __sinus trouble __hay fever __dust/animal allergies	
Ears	__hearing loss __ringing	
Mouth/Throat	Date of last dental exam: ______	__bleeding gums __dental pain __frequent sore throat __hoarseness
Neck	__goiter __lumps/swollen glands __pain __neck pain/injury/trauma	
Breasts	Date of last mammogram: _____	__lumps __pain __nipple discharge
Respiratory	Date of last chest x-ray: _______	__cough __coughing of blood __wheezing __shortness of breath
Cardiac	__heart murmur __chest pain __palpitations __swelling of feet/legs __shortness of breath (at rest / with exertion / when laying flat)	
Gastro-intestinal	__trouble swallowing __heartburn or gas __nausea __vomiting __diarrhea __constipation __abdominal pain __hemorrhoids __rectal bleeding	
Urinary	__frequent urination __painful urination __difficulty urinating/holding urine __blood in urine	
MSK	__joint stiffness __arthritis __gout __back ache __muscle spasms __muscle cramps	
Neuro-Vasc.	__fainting __blackouts __seizures __weakness __numbness __tremors __tingling in hands/feet __change in memory __leg cramps while walking	
Psych.	__anxiety __depression __phobias __eating disorder __family problems	

Do you have a Living Will or Advance Directives? __Yes __No: ________
Other Specialists YOU SEE: (NAME & SPECIALTY): ____
Will YOU be filing Workman's Compensation? Y___ N___ If Yes, Date of Injury: ______________________
Were you in an Accident (automobile or other)? Y___ N___ Type: ______________________________
Are you represented by an Attorney? Y___ N___ Name & Phone #: ___________________________

I HEREBY AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THE CLAIM TO ANY INSURANCE COMPANY RESPONSIBLE FOR PAYMENT OF THIS CLAIM.

Signature: ________________________________ Date:________________________________

NOTE: ALL ACCOUNTS & FEES ARE DUE ON THE DAY OF SERVICE UNLESS OTHER ARRANGEMENTS ARE MADE IN ADVANCE.