



Allan Warshowsky MD, FACOG, ABIHM

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Abw88pe@aol.com



New Patient Questionnaire

Date of appointment : _____

Name: _____

Address: _____ Apt# _____

City: _____ State: _____ Zip: _____

Phone: _____ Cell: _____

Email: _____ Age: _____ DOB: _____

Referred By: _____

Your occupation:

Allergies:

To Medications: _____

Other: _____

Reason for Today's Visit: _____

Level of Education: _____



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AHMA

With whom are your closest relationships? _____

What gives you most joy in your life?

What stresses you out most in life?

"What symptoms do you notice when you are stressed?"

FAMILY HISTORY:

	Alive / Deceased	current age / age at death	health problems / cause of death
MOM			
DAD			
SIBLINGS			
CHILDREN			
PARTNER			



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REVIEW OF SYMPTOMS: (check and describe all that apply)

General

Appetite (increased, decreased): _____

Weight issues: _____

Energy level (when are you most energized? When exhausted?) _____

More or less exhausted after exercise? _____

Easy bruising? _____

Sleep (cannot get to sleep, awakens and cannot fall back asleep): _____

Bedtime: _____

Awaken for the day: _____

Nighttime snack? _____ What? _____ Time? _____

Night sweats (hot flashes): _____



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Food cravings

When during menstrual cycle? _____

Skin /Hair/Nails (dry, oily, thinning, etc.): _____

Head, Ears, Eyes, Nose, Throat

Headache (migraine? Tension? When in menstrual cycle?): _____

Vision , hearing problems: _____

Sinus problems? (chronic): _____

Sore throats? (chronic): _____

Nose Bleeds: _____

Trouble with taste / smell: _____



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Cardiovascular

Blood pressure: _____

Palpitations (heart skipping beats): _____

Blood clots or thromboses (in arms or legs): _____

Fainting (or light-headed when changing position) _____

Varicose veins: _____

Chest pains: _____

Swelling (arms or legs): _____

Respiratory

Cough: _____

Frequent infections: _____

Asthma: _____

Gastrointestinal

Bowel movements (diarrhea/ constipation , how many per day, per week?) _____

Indigestion: _____

Stomach pain: _____

Reflux: _____



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Bloating (relationship to eating , foods that make it worse): _____

Hemorrhoids: _____

Nausea: _____

Rectal pain/ itching/ bleeding: _____

Genitourinary

Pain (pelvis, bladder): _____

Wake to urinate (# of times/night): _____

Blood in urine: _____

Sexually transmitted disease: _____

Frequent urination: _____

Cannot hold urine: _____

Other difficulties urinating: _____

History of bedwetting as a child: _____

Musculo-skeletal

Where, when do you have pain? Stiffness? _____



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Emotions-

Balanced: _____

Anxiety: _____

Depression: _____

Bad temper: _____

Easily stressed: _____

Memory loss: _____

GYNECOLOGIC HISTORY (women only):

Last pap: _____ Abnormal paps? _____

Last mammogram: _____ Normal? _____

Last bone density: _____ Results? _____

Pregnancies

Full term: _____ Vaginal delivery _____ Cesarean _____

Miscarriages: _____ Terminations of pregnancy: _____

Premenstrual symptoms

When do they go away? _____

Last period (date): _____

Age at first period: _____

Description of periods (Regular?): _____



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Cycle length? _____ No. of days? _____

Amount of flow (heavy- moderate-light): _____

When heaviest, how often do you change pads, tampons? _____

Pain with the period? _____

Abnormal bleeding? _____

Sexually active? _____

Birth control (if applicable) _____

Sexually transmitted diseases: _____

Breast problems: _____

OTHER MEDICAL CONDITIONS

Surgeries

Procedure

Date



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Supplements and Medications

For Men Only

Recent change in strength _____

Difficulty with erections _____

Lack of interest in sex _____

Lack of focus in work _____

Personal habits

Smoking:

Current: _____ Past: _____

Alcohol (Number of drinks per day, per week): _____

Soft drinks (Number of drinks per day, per week): _____

Caffeine (per day, per week): _____

Water (glasses per day): _____

Exercise (How often, what type): _____

Sleep (How many hours per night): _____



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Energy level (Scale of 1-10, 10 being the best): _____

Dental Care

How often do you have a dental cleaning: _____

When was the last time you had a dental cleaning: _____

Do you floss your teeth and if so, how often: _____

Do your gums bleed when brushing or flossing? _____

What would you like to accomplish with this visit? _____



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NEW PATIENTS: PLEASE READ THE FOLLOWING:

1. **Please fax this questionnaire to our office at [914-967-1624](tel:914-967-1624) at least 1-2 days before your appointment. If you cannot fax it, please email to priscillaew@gmail.com and not to Dr. Warshowsky.**

*****Please scan as one document, not 10 separate pages.*****

2. **If you have recent labs/reports you would like Dr. Warshowsky to see, you can fax those as well but NOT to exceed 20 pages at the most.**
3. **Our staff and many of our patients have chemical sensitivities. Please refrain from wearing perfume, cologne, or other scents when you come to our office.**
4. **You will have a follow up appointment about 2-3 weeks after the first one to review all the bloodwork. There is a charge for this appointment. We would appreciate a notification of 24 hours ahead of time if you have to change or cancel your follow up to avoid a cancellation charge.**
5. **We accept for payment Visa, Mastercard, a check or cash. We do not accept American Express or Discover.**
6. **Insurance: If you are not sure if your insurance pays for bloodwork done at an out of network physician's office, please call them before you come.**

Thank you for understanding our office policies.

Signature

Date



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