



**Allan Warshowsky MD, FACOG, ABIHM**

150 Purchase St. • Suite 7 • Rye, NY 10580

914 967 1630 • Fax: 914 967 1624 • [www.doctorallan.com](http://www.doctorallan.com)

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?

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What stresses you out most in life?

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

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**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: \_\_\_\_\_

**For Men Only**

Recent change in strength \_\_\_\_\_

Difficulty with erections \_\_\_\_\_

Lack of interest in sex \_\_\_\_\_

Lack of focus in work \_\_\_\_\_





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**OTHER MEDICAL CONDITIONS**

**Surgeries**

Procedure

Date

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**Supplements and Medications**

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**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): \_\_\_\_\_



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Water (glasses per day): \_\_\_\_\_

Exercise (How often, what type): \_\_\_\_\_

\_\_\_\_\_

Sleep (How many hours per night): \_\_\_\_\_

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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**AHMA**

**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](mailto: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**