Allan Warshowsky MD,FACOG, ABIHM
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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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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: _____

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

_____

_____

_____

_____

_____

_____

Supplements and Medications

_____

_____

_____

_____

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?

_____

_____

_____

_____

_____

_____

_____

Note: Please read and sign the following page.
We would appreciate it if you would please honor our request in item #2.
If you have labs and/or reports, you can send then only if they are within the last 6 months to a year.
Thank you

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NEW PATIENTS: PLEASE READ THE FOLLOWING:

1. Please fax this questionnaire to our office at 914-967-1624 at least 2 days before your appointment. Or you can email it to priscillaew@gmail.com but not to Dr. Warshowsky.

   PLEASE SCAN AS ONE DOCUMENT, NOT 11 SEPARATE PAGES
   PLEASE DO NOT TAKE A PHOTO OF EACH PAGE AS IT MUST BE FAXED OR EMAILED.

2. You will have a follow up appointment about 2-3 weeks after the first one to review all the bloodwork, and there is a charge for this appointment.

3. **CANCELLATION POLICY**: If a new patient appointment is cancelled fewer than 3 days before the appointment, there is a charge of $300.

4. If you have recent labs or reports that you would like to send with your questionnaire, you may do so but **NOT TO EXCEED 25 PAGES**.

5. **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.

6. 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.

7. **Payment:** We accept Visa, Mastercard, check or cash for payment. We do not accept American Express or Discover.

Thank you for understanding our office policies.

_____ _____
Signature Date