*Allan Warshowsky MD,FACOG, ABIHM*
**150 Purchase St. • Suite 7 • Rye, NY 10580**
**914 967 1630 • Fax: 914 967 1624 • 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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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 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***