**The Centre for Renewal**
**New Patient Questionnaire**

Please complete prior to your appointment with Dr. Traci Shahan:

1. What is your full name, date of birth and sex?

2. What are is your mailing address, email address, cell & home phone numbers?

3. What is your occupation?

4. What do you do for exercise?

5. What do you do for fun?

6. General Health:

7. What are your symptoms?

8. Have you had any of the following symptoms (circle all that apply):

| | | | |
|---|---|---|---|
| Fatigue | Chills | Headaches | Tinnitus |
| Trouble Swallowing | Chronic Cough | Constipation | Joint Paint |
| Tingling Sensations | Pelvic Pan | Frequent Urination | Neck Pain |
| Pain with sex | Anxiety | Lightheadedness | Night Sweats |
| Shortness of Breath | Sore Throat | Chest Pain or Pressure | Acid Reflux |
| Abdominal Pain | Diarrhea | Muscle Pain | Numbness |
| Pain with Urination | Mood Swings | Blurry or Double Vision | Fever |
| Changes in hair or nails | Hearing Loss | Runny Nose | Vertigo |
| Weakness | Depression | Prostate Problems | |
| Urinary Incontinence | Black or Bloody Stool | Trouble starting or stopping urination | |

9. Approximate dates of the following procedures and vaccinations:

10. Mammogram

11. Pap Smear

12. Bone Density

Name:_____
Date of Birth: _____

13. Colonoscopy

14. Flu Shot

15. Hepatitis A series

16. Hepatitis B series

17. Tetanus shot

18. Family Medical History: Please list relatives' ages, age if death if not living, and health problems:

19. Relationship Status:

20. Are you sexually active:

21. Are your partners Men, Women, Both

22. Preferred Pharmacy Name & Address

23. What are your current medications?

24. What allergies do you have?

25. What is your smoking status?

26. Dietary Restrictions:

27. List any past or present health problems here, including surgeries (include dates):

Name:_____
Date of Birth: _____

28. Menstrual/Menopause:

29. Number of Pregnancies

30. Deliveries:

31. Living children:

32. Miscarriages:

33. Abortions:

34. Name of your medical insurance:

Member ID # Group #

Policy Holder Name and Date of Birth:

35. What is your preferred language?

36. What is your race?

37. What is your ethnicity?

38. Emergency contact name, relationship, and phone number:

39. Do you feel you have a purpose in life or a spiritual path?

40. What are your health goals over the next year?

I have read and signed the Patient Agreement and answered the questionnaire to the best of my ability.

_____ _____

Patient or Guardian Signature Date

Name:_____

Date of Birth: _____