

**Mary Y. Tang, MD**  
**Concierge Mobile M.D.**  
**1527 State Hwy 114 West, Suite 500-125**  
**Grapevine, TX 76051**  
**682-223-1526**  
**817-488-6932 (fax)**  
**concierngemobilemd@gmail.com**

NEW PATIENT QUESTIONNAIRE

Name of Patient \_\_\_\_\_

Name of person completing form \_\_\_\_\_

1. WHAT MEDICATIONS ARE YOU CURRENTLY TAKING? In addition to your prescription medications, please include over-the-counter medications, vitamins and supplements.

SEE MEDICATION LIST FROM FACILITY

NAME OF MEDICINE	DOSAGE (MG)	HOW MANY PER DAY?	TAKEN EVERY DAY OR AS NEEDED?

2. DO YOU HAVE ANY DRUG ALLERGIES?                      O No                      O Yes	
NAME OF DRUG	WHAT HAPPENS WHEN YOU TAKE IT?

3. PLEASE CHECK THE CONDITIONS THAT YOU HAVE HAD IN THE PAST OR CURRENTLY HAVE.

Alcohol abuse		Heart Disease	
Anemia		Heart murmur	
Angina		Hepatitis B	
Anxiety		Hepatitis C	
Aortic stenosis		Hernia	
Asthma		Hypercholesterolemia	
Atrial fibrillation		Hypertension	
Bladder or Kidney Infection		Insomnia	
Blood Clot in Leg		Irritable bowel syndrome	
Blood Clot in Lung		Irregular heart rhythm	
Blood Clots Elsewhere		Kidney Disease	
Carpal tunnel		Low back pain	
Cirrhosis		Macular degeneration	
Colitis / Diverticulitis		Migraine headache	
Congestive Heart Failure		Neuropathy	
Constipation		Obesity	
COPD/ Emphysema		Osteoporosis	
Dementia		Peptic ulcer disease	
Depression		Pneumonia	
Diabetes		Scoliosis	
Eczema		Seizures	
Edema		Shingles	
Enlarged Prostate		Sleep apnea	
Enlarged Thyroid		Stroke	
GERD(Acid Reflux)		Thyroid Disease	
Gout		Tuberculosis	
Hay fever		Urinary incontinence	

- Please indicate any other past medical history not listed above:

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CANCER	None		
Uterine Cancer	Non-Hodgkin Lymphoma	Colon/Rectal Cancer	
Leukemia	Lung Cancer	Breast Cancer	
Ovarian Cancer	Prostate Cancer	Skin Cancer	
Urinary/Bladder Cancer	Other Cancer:		

PLEASE CIRCLE/LIST ANY SURGERIES YOU HAVE HAD:

Hysterectomy    Appendix    Gall Bladder    Breast    Prostate  
 Hip Replacement (R / L)    Knee Replacement (R / L)

SURGERY	YEAR

- Has the patient had any hospitalizations in the last year?  
 If so, please include the name of the hospital, city, state, and reason for hospitalization.

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- Are you currently signed up with a Home Health Agency for nursing or physical therapy visits?  
 (Circle one) YES / NO If Yes, with Whom \_\_\_\_\_
- When was the patient's last Bone Density Test? (circle one)  
 1. Less than 2 years ago    2. More than 2 years ago    3. Never
- Does the patient have Osteoporosis? No \_\_\_\_\_ Yes \_\_\_\_\_
- Has the patient ever had fractures? No \_\_\_\_\_ Yes \_\_\_\_\_ Where? \_\_\_\_\_

- When was the patient's last Mammogram? (circle one)  
 1. Less than one year ago    2. One year ago or more    3. Never  
 Was it normal or abnormal? (circle one)    NORMAL    ABNORMAL
- When was the patient's last colonoscopy? (circle one)  
 1. Less than 10 years ago    2. More than 10 years ago    3. Never
- Has the patient had a flu shot this season? (circle one ) YES    /    NO
- Has the patient had a pneumococcal vaccine since turning 65 years old? (circle one) YES/ NO
- When was the patient's last tetanus shot? (circle one)  
 1. Less than 5 years ago    2. 5-10 years ago    3. More than 10 years ago
- Has the patient had shingles vaccine? (circle one) YES    /    NO
- Has the patient fallen in the past three months? (circle one) YES    /    NO
- Please circle all the following devices that the patient owns.  
 1. Cane    2. Walker    3. Manual Wheelchair    4. Motorized Wheelchair    5. Scooter
- Please circle which of the following devices that the patient uses.  
 1. Cane    2. Walker    3. Manual Wheelchair    4. Motorized Wheelchair    5. Scooter

4. PLEASE ANSWER THE FOLLOWING QUESTIONS ABOUT SOCIAL HISTORY

Do you drink alcohol? \_\_\_\_\_ Yes, occasionally    \_\_\_\_\_ Yes, daily    \_\_\_\_\_ No  
 How Much? \_\_\_\_\_

Do you smoke?    \_\_\_\_\_ Yes    \_\_\_\_\_ No    \_\_\_\_\_ Smoked in the past    \_\_\_\_\_ Spouse smoked  
 How many packs per day? \_\_\_\_\_    How many years ago did you quit? \_\_\_\_\_

Do you have any children? \_\_\_\_\_ No    \_\_\_\_\_ Yes    # daughters \_\_\_\_\_    #sons \_\_\_\_\_

What is your Marital Status?  
 \_\_\_\_\_ Married    \_\_\_\_\_ Single    \_\_\_\_\_ Widowed    \_\_\_\_\_ Divorced

Where do you currently live?  
 \_\_\_\_\_ Private Home    \_\_\_\_\_ Assisted Living Facility    \_\_\_\_\_ Retirement Facility

What was your former occupation? \_\_\_\_\_

