

New Patient Questionnaire

Please complete this and bring it with you to your visit. If you have it completed five days or more prior to your visit, please mail or fax it to our office.

Most recent treating primary care doctor and date of last visit



Ongoing specialty care

HISTORY OF PRESENT HEALTH OR ILLNESS:

What goals do you have for your doctor's visit today?

PAST MEDICAL HISTORY ITEMS

A. Please include any medications (herbal, prescription, or Over-the-counter) and any supplements that you are currently taking.

Medication	Strength of dose	Times taken per day	Date started medication

B. Please include any medications (herbal, prescription, or Over-the-counter) that you **may have tried in the past and then stopped**. Please comment on why you stopped the medication.

Medication	Stop date	Reason stopped

C. Please indicate any allergies you may have, whether they are to medications or to things in the environment.

Medication or Allergen	Reaction

D. Please list any medical problems you have, and other details as able.

Medical problem	Controlled or un-controlled	Present concerns or details

E. Please list any surgeries you may have had, along with the dates as best as you can remember.

Surgery	Complications, if any	Date of Surgery (mm/yy)	Location of care

F. Recommended vaccines vary with age group and exposures. Not all vaccines are indicated in all persons. Please list your most recent dose of the following vaccines, if known.

Vaccine	Date	Any reaction
Tetanus toxoid (Td)		
TdAP		
Pneumonia (Pneumovax)		
Flu		
Pertussis		
Hepatitis A		
Hepatitis B		
Yellow Fever		
Chicken pox (varicella)		
Shingles vaccine		
MMR		

G. Do you know if you have had any of the following tests? **Only some of tests are indicated, and tend to vary with age groups.** Please identify which tests you may have had in the past.

Test performed	Date	Location & outcome
EKG		
Chest Xray		
Breathing test		
Exercise stress test		
Blood sugar test		
Liver function test		
Complete blood count		
Thyroid function check		
Colonoscopy		
Flexible sigmoidoscopy		
Stool check for occult blood		
Prostate Specific Antigen (PSA) (Men)		
Prostate exam (Men)		
Testicle exam (Men)		

Medical History

Test performed	Date	Location & outcome
Clinical breast exam (Women)		
Mammogram (Women)		
Pelvic exam (Women)		
Pap smear (Women)		
Bone density scan (DEXA)		

SOCIAL HISTORY

1. Do you exercise? _____ If so, what exercises and how many times per week?

2. Do you feel you are at your appropriate weight? _____

If not, are you now doing anything to lessen your weight? _____

Have you had success losing any weight in the past? _____

If so, what strategy did you use? _____

Do you eat five servings of fresh fruits or vegetables a day? Yes No

3. Do you use tobacco now? _____ How much per day? _____

If you used tobacco in the past, describe your usage.

4. Do you drink alcohol now? _____ What type of liquor and how many per day? _____

5. Are you presently taking care of any young children, either as a parent, grandparent, or as a job? _____ If so, please describe _____

Are you presently taking care of older persons with immunity problems? _____

If so, please describe _____

6. Do you have any pets in the house? _____

7. Have you traveled outside the country in the last year? _____

8. Are you a blood donor? Yes No Double Red Donor? Yes No

If not, would you consider becoming a donor? Yes No

Family History	Brothers	Sisters	Mother	Father	Kids
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Went on kidney dialysis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart disease before 55 in men	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart disease before 65 in women	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Breast cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ovarian cancer	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Colon cancer or colon polyps	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Medical History

Melanoma (deadly skin cancer)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Prostate cancer	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Genetic illnesses	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bipolar	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hemochromatosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid illness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

REVIEW OF SYSTEMS

Please circle any symptoms you are experiencing.

CONSTITUTIONAL

Weight loss no yes
 Weight gain no yes
 Fever no yes
 Chills no yes

EYES:

Itching no yes
 Eye dryness no yes
 Changing vision no yes

EARS, NOSE, MOUTH, THROAT:

Hearing loss no yes
 Ringing of ears no yes
 Nose bleeds no yes
 Frequent congestion no yes
 Frequent sore throats no yes
 Hoarseness no yes

CARDIOVASCULAR:

Chest pain no yes
 Lower extremity swell no yes
 Awake short of breath no yes

PULMONARY:

Chronic cough no yes
 Cough up blood no yes
 Short of breath no yes
 Wheezing no yes
 Abnormal chest x-ray no yes
 Positive PPD no yes

GASTROINTESTINAL:

Loss of appetite no yes
 Difficulty swallowing no yes
 Painful swallowing no yes
 Nausea or vomiting no yes
 Pain in abdomen no yes
 Heartburn no yes
 Colon polyps no yes
 Blood per rectum no yes
 Constipation no yes
 Diarrhea no yes
 Black (tarry) stools no yes

GENITOURINARY:

Blood or pus in urine no yes
 Getting up nights to urinate (___times) no yes
 Trouble starting urine no yes
 Incontinence no yes
 Incomplete voiding no yes
 Penis discharge (men) no yes
 Erectile dysfunction (men) no yes
 Irregular menses (women) no yes
 Vaginal discharge (women) no yes

MUSCULOSKELETAL:

Joint pain no yes
 Red, hot joints no yes
 Injury no yes

SKIN:

Changing moles no yes
 Rash no yes
 Hair changes no yes

Rash to lips, mucosa no yes
 Dry skin no yes
 Breast changes no yes

NEUROLOGIC:

Weakness no yes
 Tingling no yes
 Numbness no yes
 Fatigue no yes
 Insomnia no yes
 Headache no yes
 Tremor no yes
 Forgetfulness no yes

PSYCHIATRIC:

Inability to enjoy no yes
 Sadness no yes
 Thoughts of self harm no yes
 Thoughts of harm to others no yes

ENDOCRINE:

Excessive urine no yes
 Excessive thirst no yes
 Hair growth no yes
 Heat or cold intolerance no yes
 Growing hands/feet no yes

HEMATOLOGIC:

Low blood counts no yes
 Armpit, neck or groin swelling no yes

ALLERGIC:

Hay fever no yes
 Frequent infections no yes

Medical History

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