New Patient History Questionnaire

Name_____ **Appointment Date:** _____

Birthdate: ____/_____/_____ **Age:** _____ **Gender:**_____
Marital Status: __ **Single** __ **Married** __ **Other**

Reason for visit: □ **Annual Exam** □ **Problem(s)**

Please give brief description of problem(s):

Do you have any known allergies: □ **No** □ **Yes, please list allergy**

Please list all medical conditions:

Please list any past surgeries and year:

Are you presently taking any medication(s)? If yes, please list medication below:

Medication Name	Dose	Frequency	For what illness?

Have you been admitted to a hospital during the past 5 years? Yes or No. If yes, please list the name of the hospital, date(s) of admission and reason.

Date(s)	Name of Hospital	Reason for Admission

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Birthdate: ____/_____/_____

Please answer the following questions by checking YES or NO.

Yes	No		
		Do you currently smoke cigarettes?	If yes, packs per day: Years of use:
		Other tobacco products	How often:
		What type:	Years of use:
		Did you quit smoking?	If yes, how long ago?
		Do you drink alcohol?	If yes, how many drinks per week?
		Do you use recreational drugs?	If yes, please list:
		Are you sexually active?	□ Men □ Women □ Both
		How many partners in lifetime?	
		History of sexually transmitted disease?	
		Have you ever been abused?	□ No □ Yes
			□ Physically □ Sexually □Emotionally

If any of your family members (parents, siblings, children) have been diagnosed with the following condition(s), please indicate by completing the following:

Yes	No	Medical Condition	If YES, please indicate family member
		Breast Cancer	
		Colon Cancer	
		Uterine or Ovarian Cancer	
		Other Cancer	
		Heart Disease	
		High Blood Pressure	
		Asthma	
		Tuberculosis	
		Lung Disease	
		Diabetes	
		Anemia	
		Hepatitis	
		Arthritis	
		Kidney Disease	
		Stroke	
		Birth Defect	
		Osteoporosis	
		Glaucoma	
		Mental Condition	
		Drug or Alcohol Addiction	
		Hereditary Disease (please specify)	
		Other (please specify)	

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Birthdate: ____/_____/_____

Review of Symptoms

Please fill out this section carefully. The doctor will review the form and ask you about any **"YES"** responses during the course of your visit. Please be assured that this information is strictly confidential.

Do you have any current or recent health problems? Check YES or NO in the column before each problem.

Yes	No	Constitutional	Yes	No	Gastrointestinal	Yes	No	Neurological
		Weight change			Indigestion/Heartburn			Headache/Migraine
		Appetite change			Stomach/abdominal pain			Vertigo
		Fever			Constipation			Disorientation
		Excessive fatigue			Diarrhea			Fainting/blackout spells
		Night sweats			Change in bowel habits			Seizures
					Rectal bleeding			Numbness, tingling
		Eyes			Polyps			Weakness
		Blurred vision			Hemorrhoids			Coordination problems
		Redness/Discharge			Nausea/Vomiting			Memory Loss
		Double vision			Decreased appetite			Tremors
		Light sensitivity			Belching/Bloating			
								Psychiatric
		Ears/Nose/Throat			**Genitourinary**			Anxiety
		Hearing loss			Pain/burning w/urination			Depression
		Hearing aid			Blood in urine			Panic attacks
		Pressure or ringing in ears			Difficulty urinating			Difficulty concentrating
		Pain in ear			Incontinence			Mood Swings
		Dizziness			Vaginal/Penile discharge			
		Nasal congestion			Erectile dysfunction			**Endocrine**
		Runny nose			Pain during intercourse			Diabetes
		Nosebleeds			Frequent urination			Hormone problems
		Tooth/Gum bleeding			Frequent UTI			Low blood sugar
		Sore throat						Thyroid disease
		Difficulty swallowing			**Musculoskeletal**			Excessive thirst
		Change in taste			Joint pain or swelling			Excessive urination
		Hoarseness			Stiffness			Pituitary gland problems
					Difficulty walking			Excessive/night sweating
		Cardiovascular			Muscle twitching or pain			
		Chest pain						**Hematologic**
		Arm and leg swelling			**Integumentary/Skin**			Easy bleeding/bruising
		Palpitations			Itching			Swollen glands
		Leg pain			Rash			
					Dry Skin			**Immunologic**
		Respiratory			Changes in skin color			Hay fever
		Exercise induced cough			Changes in moles			Food allergies
		Shortness of breath			Excessive sweating			Immune system problems
		Cough			Breast pain or swelling			Connective tissue disease
		Wheezing			Ulcers			Frequent colds/infection
		Blood in sputum						Environmental allergies
		Oxygen use at home						

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Please answer the following questions by checking YES or NO.

Yes	No	Immunization	If YES, please indicate month/year
		Flu Shot for this year	When:
		Tetanus	When:
		Pneumonia	When:
		Hepatitis B	When:
		Rubella	When
		Hepatitis A	When:
		Varicella (Chicken Pox)	When:
		History of Chicken Pox	When:
		Tested for Tuberculosis (PPD or tine)	When: Positive: Y or N
		Tuberculosis Exposure?	
		Other	

Please provide the name of your primary care doctor:

Name: _____

Address: _____Phone Number: _____

If you have other doctors who are involved with your care please provide information below*:

Name	Specialty:

*If you have multiple medical conditions, please include the names of each doctor involved in your care

I understand the above information is necessary to provide me with surgical/medical care in a safe and efficient manner. I have answered all questions to the best of my knowledge.

Patient/Guardian Signature:_____ Date:_____

I have reviewed the form and discussed it with the patient.

Attending Physician Signature:_____ Date:_____

New Patient History Questionnaire

Name_____ **Appointment Date:** _____

Birthdate: ____/_____/_____

Screening (please supply month and year if applicable)

Yes	No	Screening Test	If yes, when?
		Last Physical Exam	
		Colonoscopy	
		Flexible Sigmoidoscopy	
		Stool Cards (to evaluate for colon cancer)	
		PSA Testing (prostate cancer screening)	
		Cholesterol Level	
		Digital Rectal Exam	
		Bone Density	

Please answer the following questions by checking YES or NO.

Yes	No		
		Do you drink coffee or tea?	
		Do you exercise?	If yes, times per week? Duration:
		Do you follow a particular diet?	If yes, which kind?
		What is your occupation?	
		Do you have children?	If yes, how many?
		Do you wear a seatbelt?	
		Do you wear a bike helmet?	
		Do you use sunscreen?	
		Is there a gun in your home and is it out of children's reach and unloaded?	
		Have you ever worked with Chemicals, paints, asbestos or other hazardous materials?	
		Do you have a living will?	If yes, did you bring a copy with you?
		Do you have a donor card?	
		Are you currently pregnant?	□ No □ Yes
			If yes, # of months:
		Are you nursing?	□ No □ Yes

New Patient History Questionnaire

Name_____ **Appointment Date:** _____

Birthdate: ____/_____/_____

Woman's Health History

Menstrual History

Age of first period:	
How frequent are periods?	
Flow is	□ Light □ Average □ Heavy
How many days?	
Do you have any symptoms associated with periods?	
When was first day of last period?	
Are you menopausal?	□ No □ Yes If yes at what age:
Do you having any premenopausal symptoms? (Specify)?	
Have you ever been on hormone therapy?	At what age:
What medications and when?	

PAP History

Date of last PAP:	Date: □ Never had a PAP
Have ever had an abnormal PAP?	□ No □ Yes
What was diagnosis?	
What was treatment?	
Have ever had a sexually transmitted infection(s)?	□ No □ Yes
If yes what infection and when?	

Breast History

When was your last mammogram:	Date: □ Never had mammogram
Have you ever had an abnormal mammogram?	□ No □ Yes If yes, when:
What was the finding:	
Do you have any breast discharge?	□ No □ Yes
Have you ever had a breast biopsy?	□ No □ Yes If yes, when:
What was diagnosis?	
What was treatment?	
Do you do monthly self-breast exams?	□ Yes □ No

New Patient History Questionnaire

Name_____ Appointment Date: _____

Birthdate: ____/_____/_____

Obstetric History

Have you ever been pregnant?	□ No □ Yes If yes answer all questions
How many pregnancies?	
How many babies did you deliver?	
Have you ever had a miscarriage?	□ No □ Yes If yes how many:
Have you ever had an abortion?	□ No □ Yes If yes how many:
Have you ever had a tubal/ectopic pregnancy?	□ No □ Yes If yes how many:
Have you ever had any premature births?	□ No □ Yes If yes how many:

Child Birth History

#	Sex of Baby	Year of Birth	Weeks Pregnant	Weight of Baby	Vaginal or C-Section	Complications

I have reviewed the above information and discussed all pertinent findings with the patient.

_____ _____

Attending Signature ***Date***