Patient NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

New Patient Questionnaire

|  |
| --- |
| N Name: Age: Marital Status: S M D W |
| Employer: Position: |
| Reason for Visit |
| PREVENTIVE HEALTH |
|  | Date of last: |  | Date of last: |  | Date of last: |  | Date of last: |
| Colonoscopy |  | GardasilDid you receive all 3? |  | Bone Density Scan? |  | Tetanus |  |
| Pap Test |  | Mammogram |  | HIV test? |  | Bone Density |  |
| Was last pap: □Normal □Abnormal Any previous abnormal Paps? date \_\_\_\_\_\_\_\_\_ Treatment \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| PAST MEDICAL HISTORY: please check (X) ALL areas that apply to you. |
| Vaginal Infections - History of : □Trichomonas□ Chlamydia □ Herpes □ Gonorrhea□Other STDs |
| * 􏰀  Arthritis
* 􏰀  Asthma
* 􏰀  Anemia / blood disorder
* 􏰀  Bowel/Stomach disorders
* 􏰀  Diabetes
* 􏰀  Hepatitis
* 􏰀  Heart disease
 | * 􏰀  High blood pressure
* 􏰀  Kidney/bladder problems
* 􏰀 Cancer
* Type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* 􏰀  Seizures/epilepsy
* 􏰀  Serious injuries
* 􏰀 Severe headaches
 | 􏰀  Skin disease * 􏰀  Thyroid disease
* 􏰀  Urinary incontinence
* 􏰀  Other
 |
| SURGERIES (excluding pregnancy) |
| Year | Description | Year | Description |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
| Medications’ | Frequency of Dose |
|  |
|  |
|  |
|  |  |  |  |
| DRUG ALLERGIES | REACTION | REACTION |
|  |  |  |
|  |  |  |  |
| FAMILY HISTORY: Have any of your close relatives had any of the following conditions? |
| Condition: | Relation to you | Condition: | Relation to you | Maternal/Paternal | Diag. Age |
| 􏰀 Blood disorder |  | 􏰀 High blood pressure |  |  |  |
| 􏰀 Breast cancer |  | 􏰀 Kidney disease |  |  |  |
| 􏰀 Cancer |  | 􏰀 Lung disease |  |  |  |
| 􏰀 Diabetes |  | 􏰀 Ovarian cancer􏰀 Stroke |  |  |  |
| 􏰀 Heart attack/Heart disease |  |  |  |  |
| SOCIAL HISTORY |
| Smoking 􏰀 Yes 􏰀 No (# cigs. Per day? ) Alcohol 􏰀 Yes 􏰀 No \_\_\_\_Drinks/Week Street drug􏰀 Yes 􏰀 No Type: |
| Caffeine Tea/Coffee \_\_\_\_\_\_ cups/day Colas \_\_\_\_\_\_cans/day |
| Exercise: 􏰀 None \_\_\_\_\_times per week Activity: |
| Sexual History: □ Satisfactory □ Uncomfortable □ Wish to discuss |
| MENSTRUAL HISTORY |
| Age at 1st period \_\_\_\_\_Date of last period (1st day) \_\_\_\_\_\_\_ Period Interval (1st day to 1st day) # of days \_\_\_\_\_\_ Duration of bleeding: # of Days \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_􏰀 Mild 􏰀 Moderate 􏰀 Severe Medication for cramps \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Menopausal Yes, I am􏰀Pre􏰀 Post or 􏰀 NoneHave you had a hysterectomy? 􏰀 Yes 􏰀 No |
| Contraceptive History: Current Method: Past methods: |
| OBSTETRICAL HISTORY |
| Total Preg:\_\_\_\_\_ Full Term Births\_\_\_\_\_ Premature Births\_\_\_\_\_ No. of Abortions Induced \_\_\_\_\_ |
| No. of Abortions: Spontaneous\_\_\_\_\_\_ Ectopic Births \_\_\_\_\_\_ Multiple Births (twins) \_\_\_\_\_\_ Living Children\_\_\_\_\_ |
| Month / Day / Year | Weeks Preg. | Weight | Sex | Type of Delivery | Remarks |
| 1) |  |  |  |  |  |
| 2) |  |  |  |  |
| 3) |  |  |  |  |  |
| 4) |  |  |  |  |  |
| 5) |  |  |  |  |  |
| 6) |  |  |  |  |  |
| **ANY ADDITIONAL INFORMATION YOU WISH TO SHARE:****PLEASE CHECK (X) IF YOU ARE CURRENTLY EXPERIENCING ANY OF THE FOLLOWING…** |
| CONSTITUTIONAL􏰀 Weight loss 􏰀 Weight gain 􏰀 Fever 􏰀 Fatigue | CARDIOVASCULAR􏰀 Painful breathing 􏰀 Chest pain 􏰀 Difficult breathing on exertion 􏰀 Swelling of legs 􏰀 Palpitations of heart | SKIN |
| 􏰀 Rash 􏰀 Ulcers |
| NEUROLOGIC |
| 􏰀 Dizziness 􏰀 Seizures 􏰀 Numbness 􏰀 Trouble walking |
| EYES􏰀 Double vision 􏰀 Spots before eyes 􏰀 Vision changes | RESPIRATORY􏰀 Wheezing 􏰀 Spitting up blood 􏰀 Shortness of breath 􏰀 Cough, chronic |
| MUSCULOSKELETAL |
| EARS, NOSE, THROAT􏰀 Ear aches 􏰀 Ringing in ears 􏰀 Sinus problems 􏰀 Sore throat 􏰀 Mouth sores 􏰀 Dental problems | 􏰀 Muscle weakness |
| ENDOCRINE |
| GASTROINTESTINAL􏰀 Frequent diarrhea 􏰀 Bloody stool 􏰀 Nausea/vomiting 􏰀 Constipation | 􏰀 Dry skin 􏰀 Abnormal thirst 􏰀 Hot flashes |
| PSYCHIATRIC |
| 􏰀 Depression 􏰀 Frequent crying |
| BREASTS􏰀 Pain in breast 􏰀 Discharge 􏰀 Masses 􏰀 Implants | GENITOURINARY􏰀 Blood in urine 􏰀 Pain with urination 􏰀 Urgency 􏰀 Frequency of urination 􏰀 Incomplete emptying 􏰀 Stress incontinence 􏰀 Abnormal periods 􏰀 Painful intercourse |
| HEMATOLOGIC/LYMPHATIC |
| 􏰀 Easy bruising 􏰀 Enlarged lymph nodes 􏰀 Easy bleeding |
| MOOD􏰀 Anxiety􏰀 Depression 􏰀 Frequent crying spells |