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

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

New Patient Questionnaire

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| 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 | |  | | | Gardasil  Did 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 | | | | | | | |
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| Medications’ | | | | | | | | | | | | | | | | | | | Frequency of Dose | | |
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| DRUG ALLERGIES | | | | | REACTION | | | | | | | | | | | REACTION | | | | | |
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| 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 􏰀 None  Have 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 | | | | | | |