New Patient Health Questionnaire

Part I

Name: _____ Date: _____

DOB: _____ Age: _____ New Patient____ Established ____

PLEASE NOTE: **This is a confidential record of your medical history and will be kept in this office. Information contained here will not be released to any person except when you have authorized us to do so.**

What medical concerns bring you to our office? _____

Marital Status: *(circle)* S M D W Occupation: *(if retired, previous occupation)* _____

If disabled, check here:____ Nature of disability _____ Birthplace: _____

Do you exercise routinely? *(circle)* No Yes If *Yes*, what exercise/how often? _____

Have you ever smoked? *(circle)* No Yes Cigar Pipe Cigarettes If *Yes*: #cigarettes/day_____#yrs._____

If you have never smoked, skip this question: Do you still smoke now? *(circle)* No Yes If *No*, when did you quit? _____

Have you completed Advanced Directives or do you have a Living Will? *(circle)* No Yes Which? _____

Caffeine: Do you drink *(circle)* caffeinated coffee, teas or sodas regularly? *(circle)* No Yes #/day _____

Tell us a little about your home environment: *(e.g. live alone, with family, single parent, house, apt., etc.)*

_____

Are you under a lot of pressure at work or at home? *(circle)* No Yes, Which? _____

Medical Information

Allergies: Are you allergic to any drugs? *(circle)* No Yes Please list: _____

Medications *(list all medications you are taking regularly. Include over the counter, herbal or natural remedies.)*

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Medical Illnesses or Conditions *(list any chronic conditions which you have been diagnosed to have)*

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Have you ever had or been diagnosed to have: *(check box by all that apply)*

Cataracts		Heart Disease		Ulcers		Anemia		Depression	
Glaucoma		Heart Murmur		Digestive Disorder		Bleeding Disorders		Frequent Infection	
Asthma		High Blood Pressure		Hemorrhoids		Bone or Joint Disease		Cancer (type)	
Allergies		Pneumonia		Kidney Disease					
Stroke		TB/Lung Disease		Kidney Stone(s)		German Measles		High Cholesterol	
Seizures/Epilepsy		Pleurisy		Diabetes or PreDiabetes		Rheumatic Fever		Prostate Enlargement	
Heart Attack or Angina		Jaundice or Liver Disease				Chicken Pox			
				Thyroid Disease		Syphilis			

Operations:
Please list any surgery and approximate year

Year	Surgery

Hospitalizations:
Other than operations

Year	Reason	Hospital

Family Medical History	Age	Health *(list significant illness)*	Age at Death	If deceased, cause	Comments
Father					
Mother					
Brothers or Sisters					
Spouse					
Children					

Has any blood relative ever had? *(check if Yes and indicate relationship)*

___ Alzheimer's _____ ___ Heart Attack before age 55____ ___ Alcoholism_____
___ Tuberculosis_____ ___ Bleeding Disease_____ ___ Mental Disorder_____
___ Diabetes _____ ___ Stroke_____ ___ Allergies_____
___ High Blood Pressure_____ ___ Seizures_____ ___ Asthma_____
___ Heart Disease _____ ___ Depression/Suicide_____ ___ Cancer_____

Immunizations *(check if Yes and indicate year of last injection)*

___ Influenza _____ ___ Pneumonia _____ ___ MMR _____
___ Tetanus _____ ___ Hepatitis A or B_____ ___ Other _____

Transfusions: Have you ever had a blood or plasma transfusion *(circle)* No Yes

Weight: What is your weight now? _____ One year ago? _____ Maximum? _____ When? _____

Females Only: Are you pregnant, planning a pregnancy or nursing a child? *(circle)* No Yes

Date of last menstrual period?_____

Please continue to the next page

New Patient Health Questionnaire

Part 2

Name: _____ **DOB/ID:** _____

Systems Review: Please indicate those items that have been a recurrent or a recent significant change.

Yes	No	
		Constitutional Symptoms
___	___	Good health lately
___	___	Recent significant weight change
___	___	Unusual fatigue or weakness
___	___	Frequent headaches
		Eyes
___	___	Change in vision
___	___	Blurred or double vision
___	___	Eye disease or injury
___	___	Wear glasses/contact lenses?
		Ears/Nose/Mouth/Throat/Neck
___	___	Do you wear hearing aids?
___	___	Hearing loss or ringing in ears?
___	___	Earaches or drainage?
___	___	Chronic sinus problems or runny nose
___	___	Nose bleeds
___	___	Mouth sores
___	___	Bleeding gums
___	___	Sore throat/hoarseness or voice change
___	___	Lumps or swollen glands in neck
___	___	Difficulty swallowing
___	___	Neck pain or stiffness
		Cardiovascular
___	___	Heart trouble
___	___	Chest pain or angina pectoris
___	___	Palpitations
___	___	Shortness of breath with walking or lying flat
___	___	Swelling feet, ankles or hands
___	___	Waking at night with shortness of breath
		Respiratory
___	___	Chronic or frequent cough
___	___	Coughing or spitting up blood
___	___	Shortness of breath
___	___	Asthma or recurrent wheezing
		Gastrointestinal
___	___	Loss of appetite
___	___	Change in bowel movements
___	___	Nausea or vomiting
___	___	Painful bowel movements or constipation
___	___	Frequent diarrhea
___	___	Rectal bleeding or blood in stool
___	___	Stomach/abdominal pains or heartburn
___	___	Black or tarry stools

Comments: _____

_____

_____

Yes	No	
		Genitourinary
___	___	Frequent urination
___	___	Burning or pain on urination
___	___	Blood in urine
___	___	Change in force or strain when urinating
___	___	Incontinence or dribbling of urine
___	___	Sexual difficulties
___	___	Men: Testicular pain
___	___	Women: Painful periods
___	___	Irregular periods
___	___	Recurrent vaginal discharge

Number of pregnancies (including miscarriages):_____

_____ # Deliveries _____ #Miscarriages

Method of birth control (if applicable)_____

Menopausal, since when: _____

Date of last menstrual period:_____

Date of last pap smear:_____

Date of last mammogram:_____

Yes	No	**Musculoskeletal**
___	___	Joint pain(s)
___	___	Joint stiffness/swelling or warmth
___	___	Weakness of muscles or joints
___	___	Muscle pain or recurrent cramps
___	___	Back pain
___	___	Cold hands or feet
___	___	Difficulty in walking
		Integumentary (Skin/Breast)
___	___	Rashes or itching
___	___	Change in skin color or moles
___	___	Change in hair or nails
___	___	Varicose veins
___	___	Breast pain
___	___	Breast lump
___	___	Breast discharge or rash
		Neurological
___	___	Frequent, recurring or increasing headaches
___	___	Light-headedness or dizziness
___	___	Convulsions, seizures or spasms
___	___	Numbness or tingling sensations
___	___	Tremors
___	___	Paralysis
___	___	Stroke
___	___	Head injury

Please complete other side of form: *Over please*

Name_____

DOB:_____ Age:_____

PLEASE NOTE: This section of the medical history contains questions that may be of a very personal and highly confidential aspect of your health. While we treat all information in your medical chart as confidential records, this section of the questionnaire is filed separately from the general medical data. It can be released only upon written consent from you for psychiatric, mental health and substance abuse records.

The following sets of questions are to help us identify problem areas that may be difficult to discuss. Circle yes or no to each question and discuss any *yes* answers with your physician or nurse practitioner.

Do you drink alcohol? (circle) *No Yes* If Yes, check the following:

_____Rarely social (less than once/wk)
_____Beer, 12 oz./day
_____Wine, 1 glass/day
_____Hard liquor, 1-3 oz./day
_____Beer, 2 bot./day
_____Wine, 2 glasses/day
_____Hard liquor, over 3 oz./day
_____Beer, 3 bot. or more /day
_____Wine, 3 or more glasses/day

Do you use regularly or have you used in the past marijuana, cocaine, heroin, speed, crack or other inhalants? *No Yes*

Have you felt you need alcohol or other drugs (such as wine, beer, hard liquor, pot, coke, heroin, or other inhalants)? *No Yes*

Have you felt that you use too much alcohol or other drugs? *No Yes*

Have you tried to cut down or quit drinking alcohol or your use of drugs? *No Yes*

Do you feel you have a drinking or a drug problem at this time? *No Yes*

Personal Safety

Do you feel safe at home? *No Yes*

We all have arguments - when you and your partner or a family member argue, have you ever been physically hurt or threatened? *No Yes*

Do you feel your partner or a family member controls (or tries to control) your behavior too much? *No Yes*

Does he or she threaten you? *No Yes*

Has your partner (or a family member) ever hit, pushed, shoved, punched or kicked you? *No Yes*

Have you ever felt forced to engage in unwanted sexual acts or sexual contact with your partner or other family member? *No Yes*

Mental Health

Have you been diagnosed to have depression? *No Yes*

Have you been diagnosed to have bipolar disorder, obsessive compulsive disorder, or other psychiatric condition? *No Yes*

HIV Exposure

Have you ever been diagnosed to be HIV Positive? *No Yes*

Do you have any concerns about possible exposure that you would like to discuss or be tested for? *No Yes*