NEW PATIENT HISTORY AND PHYSICAL QUESTIONNAIRE

NAME: ____ DOB:_______AGE: _____ DATE: ________

REASON FOR VISIT: ____

INSTRUCTIONS: Be as complete as possible & add comments to help us care for you

Section 1: VACCINATIONS

Section 1 - please check off all vaccines and year last received

	Date			Date			Date
Tetanus/Td	______		Tdap:			MMR:	
Flu	______		Tetanus	______		Red Measles	______
Pneumonia	______		Diphtheria	______		Mumps	______
Hepatitis B	______		Whooping C.	______		Measles	______
Hepatitis A	______						
Meningitis	______						
Chicken Pox	______						
TB							

Section 2: REVIEW OF SYSTEMS

Section 2 - please check off the symptoms you have had in the past 4 weeks

CONSTITUTIONAL

________ fever
________ chills
________ weight gain
________ weight loss
________ fatigue weakness
________ night sweats
________ Other

NOSE

________ congestion
________ bleeding
________ sinus pain
________ do you snore?
________ hay fever
________ Other

MUSCULOSKELETAL

________ joint pain
________ joint swelling joint
________ redness joint
________ stiffness muscle
________ stiffness muscle
________ weakness muscle
________ pain morning
________ stiffness
________ date/bone density
________ Other

EYES

_______ double vision
_______ blurred vision
_______ date/last eye exam
_______ Other

____

THROAT/MOUTH

_______ pain
_______ hoarseness
_______ dental problems
_______ neck pain
_______ Other

GENITOURINARY

_______ bedwetting
_______ birth control type

____

_______ Other

RESPIRATORY

_______ Pleurisy
_______ Shortness of breath
_______ in last week
_______ on exertion
_______ lying flat
_______ affects work life
_______ Other

EARS

_______ decreased hearing
_______ ear pain
_______ ringing
_______ Other

PULMONARY

_______ cough
_______ shortness of breath
_______ stop breathing during sleep?
_______ doze-off easily during the day?
_______ Other

INTEGUMENTARY

_______ rashes
_______ hives
_______ Other

HEMATOLOGICAL

_______ fatigue
_______ easy bruising
_______ excessive bleeding
_______ Other

Patient Name (print) ____ Date: ______________________________

CONTINUED ---- Section 2: REVIEW OF SYSTEMS

PSYCHOLOGICAL/EMOTIONAL

________ depression
________ loss of interest in things you used to enjoy
________ decreased motivation
________ decreased energy
________ memory loss
________ phobias
________ concentration problems
________ agitation
________ insomnia
________ thoughts of dying
________ irritable or anxious
________ crying spells
________ decreased / increased appetite
________ hallucinations / hearing voices
________ decreased libido/interest in sex
________ worry a lot
________ obsessive or compulsive
________ Other

ENDOCRINE

________ diabetic
________ checking blood sugars
________ numbers _____________
________ cold intolerant
________ heat intolerant
________ hot flashes
________ thirsty all the time
________ urinate a lot
________ hungry all the time
________ hair loss-progressive
________ hair loss-recent
________ Other

CARDIOVASCULAR

________ chest pain
________ palpitations
________ ankle swelling
________ night time urination
________ swollen ankles
________ irregular pulse
________ varicose veins
________ phlebitis
________ bruise easily
________ cold, numb feet
________ Other

NEUROLOGICAL

_______ numbness
_______ weakness
_______ pain
_______ headache
_______ dizziness
_______ loss of coordination
_______ loss of balance
_______ passing out
_______ tremor
_______ Other

UROGENITAL SYSTEM

_______ urine frequency
_______ urine burning urgency
_______ night time urination
_______ hesitancy
_______ dribbling incontinence
_______ weak stream
_______ discharge (vaginal or penile)
_______ sores/ulcers
_______ vaginal odor
_______ abnormal bleeding
_______ sexual problems
_______ menstrual problems
_______ Other

GASTROINTESTINAL

_______ indigestion
_______ heart burn
_______ abdominal pain
_______ nausea
_______ excessive belching
_______ bloating
_______ excessive gas
_______ diarrhea
_______ constipation
_______ hemorrhoid pain
_______ difficulty swallowing
_______ bloody, tarry stools
_______ test date ___________
_______ Other

Patient Name (print) ____ Date: __________________________________

Section 3: PAST MEDICAL HISTORY

Section 3 - please check off past and present medical problems and surgeries

HEAD AND NECK PROBLEMS

________ glaucoma
________ cataracts; any surgery?
________ other eye surgery
________ ear surgery
________ mastoiditis
________ Meniere's Disease
________ inner-ear infection
________ chronic sinusitis
________ chronic nasal allergies
________ nasal polyps
________ nose or sinus surgery
________ dental surgery
________ tonsillectomy
________ carotid artery surgery
________ Other

GASTROINTESTINAL PROBLEMS

________ esophagitis/reflux/GERD
________ hiatal hernia
________ stomach or duodenal ulcer
________ gastritis or duodenitis
________ colon polyps
________ last colonoscopy? (month/year)
________ diverticulosis
________ colitis (Crohn's or ulcerative)
________ hemorrhoids (any surgery?)
________ stomach or bowel surgery
________ gall stones/surgery
________ pancreatitis
________ hepatitis
________ jaundice
________ spleen problem/surgery
________ groin hernia/surgery
________ ventral or umbilical hernia/surgery
________ appendicitis/surgery
________ Other

BREAST PROBLEMS

________ breast cancer/surgery
________ fibrocystic breast disease
________ breast biopsies
________ mammogram (month/year)
________ Other

____

CARDIAC PROBLEMS

________ heart attack; when?
________ angina (heart pain)
________ cardiac stress test
________ coronary angiography (heart cath)
________ heart bypass surgery; when?
________ other heart surgery
________ heart murmur
________ heart failure
________ hypertension (high blood pressure)
________ pericarditis
________ high cholesterol
________ pacemaker
________ rheumatic fever
________ Other

PULMONARY PROBLEMS

________ asthma
________ chronic bronchitis
________ emphysema
________ interstitial lung disease
________ pneumonia
________ valley fever
________ tuberculosis
________ Other

ENDOCRINE PROBLEMS

________ hypothyroid
________ hyperthyroid
________ diabetes
________ menopause
________ thyroid surgery (when?)
________ Other

PSYCHIATRIC PROBLEMS

________ depression
________ anxiety disorder
________ panic disorder
________ manic depressive or bipolar disorder
________ schizophrenia
________ obsessive/compulsive disorder
________ suicide attempts
________ Other

Patient Name (print) ____ Date: ______________________________

CONTINUED -------- Section 3: PAST MEDICAL HISTORY

UROGENITAL PROBLEMS

- ________ frequent bladder infections
- ________ kidney infection/stones
- ________ other kidney problems
- ________ incontinence
- ________ bladder surgery
- ________ kidney surgery
- ________ prostate exam (month/year)
- ________ PSA (month/year)
- ________ prostate surgery
- ________ kidney cancer/surgery
- ________ bladder cancer/surgery
- ________ prostate cancer/surgery
- ________ ovarian cancer/surgery
- ________ uterine/endometrial cancer
- ________ hysterectomy: with or w/o ovary removal?
- ________ cervical cancer/surgery
- ________ genital warts
- ________ herpes
- ________ gonorrhea/chlamydia/syphilis
- ________ HIV/AIDS
- ________ PMS (premenstrual tension syndrome)
- ________ endometriosis
- ________ impotence
- ________ menopause (age of onset)
- ________ last pap smear (month/year)
- ________ pregnancy
- ________ miscarriages
- ________ (list dates and how many weeks)

  ____
- ________ Other

MUSCULOSKELETAL PROBLEMS

- ________ rheumatoid / osteo arthritis
- ________ gout
- ________ lupus
- ________ scleroderma
- ________ fibromyalgia
- ________ joint surgery
- ________ herniated disc
- ________ osteoporosis
- ________ other back problems
- ________ Raynaud's disease
- ________ foot problems
- ________ Other
- ________

HEMATOLOGY/LYMPHATIC PROBLEMS

- ________ anemia
- ________ bleeding
- ________ hypercoagulable disorder
- ________ lymphoma
- ________ Hodgkin's disease
- ________ leukemia
- ________ Other

CHILDHOOD DISEASES

- ________ whooping cough
- ________ measles
- ________ mumps
- ________ rubella
- ________ chicken pox
- ________ polio
- ________ rheumatic fever
- ________ Other

DERMATOLOGICAL PROBLEMS

- ________ eczema
- ________ psoriasis
- ________ seborrhea dermatitis
- ________ warts
- ________ melanoma
- ________ basal cell skin cancer
- ________ squamous cell skin cancer
- ________ actinic keratosis (pre-cancer sun damage)
- ________ athlete's foot
- ________ Other

NEUROLOGICAL PROBLEMS

- ________ stroke
- ________ TIAs (pre-stokes)
- ________ neuropathy
- ________ carpal tunnel syndrome
- ________ multiple sclerosis
- ________ epilepsy/seizures
- ________ Parkinson's disease
- ________ vitamin B12 deficiency
- ________ migraine headaches
- ________ tension headaches
- ________ cluster headaches
- ________ sinus headaches
- ________ dementia (e.g. Alzheimer's)
- ________ Other

Patient Name (print) ____ Date: ________________________________

Section 4: SOCIAL HISTORY AND HABITS (check all that apply)

Section 4 - please document your social and family history

Smoke:

Yes/no Previously Smoked
packs/day? ____ # years? ____ Date quit?____

Yes/no Currently smoke:
packs/day? ____# years you have smoked? ____

Alcohol:

Yes/no Used to drink alcohol
days/week? ____ # per day? ____ Date quit? ____

Yes/no Currently drink alcohol
days/week? ____ # per day? ____

Recreational Drugs:

Yes/no Ever inject recreational drugs what years? ________

Yes/no Currently inject recreational drugs

Yes/no Any HIV or Hepatitis risk factors?
Please List

Yes/no Occupation history (list occupations and any chemical exposures):

Other

Yes/no Do you have a living will?

Yes/no Do you have a medical power of attorney?

Yes/no Do you have a durable power of attorney for your finances? Yes/no Who?
Circle all that apply: single, married, divorced, widowed

Religious preference: ____

Family Members	Alive or Death	Current Age or age at death	Heart Disease	Cancer	Stroke	High BP or Cholesterol	Diabetes	Other
	A / D			Type				
Father								
Mother								
Siblings:								
Children:								

Patient Name (print) ____ Date: ______________________________

SECTION 5: MEDICATIONS, VITAMINS AND HERBALS

Section 5 - please list all of your medications, doses and when you take them.
Include all over-the-counter medications and herbals

Medication Allergies: ____________________

Food Allergies: ____________________

Other Allergies: ____________________

Pharmacy Name: ____________________ Phone: ____________________

	MEDICATION	DOSE (mg, grams, units, etc)	# PILLS AND WHEN YOU TAKE
	Example: Tylenol	*500 mg (ex strength*	*2 pills at 8am and 10pm*
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			
13			
14			
15			

Patient Name (print) ____________________ Date: ____________________