

New Patient Medical Questionnaire

NAME _____

DATE _____

AGE _____ BIRTH DATE _____

SEX: MALE FEMALE

OCCUPATION _____

Do you have a living will or DPOA? Yes No

MARITAL STATUS:

Married Divorced
Widowed Single

ETHNIC BACKGROUND:

Black, not Hispanic Asian
Native American White
Hispanic Other _____

Do you have special needs?

Yes No
If yes, explain _____

Education Level: _____

LANGUAGE SPOKEN IN HOME: _____

SURGERY OR HOSPITALIZATION (List any surgeries or hospitalizations you have had)

Year	Surgery or Hospitalization
a) _____	_____
b) _____	_____
c) _____	_____

Year	Surgery or Hospitalization
d) _____	_____
e) _____	_____
f) _____	_____

PAST ILLNESSES (Circle any illnesses you have had)

Respiratory

Asthma
Emphysema/COPD
Pneumonia
Tuberculosis

Heart

Congestive Heart Failure
Heart Attack
High Blood Pressure
Palpitations

Abdomen

Kidney Disease
Liver Disease
Sexually Transmitted Infection

Nerves

Anxiety/Depression
Alzheimer's Disease
Seizures
Stroke

Hormone

Diabetes
High Cholesterol
Thyroid Disease

Blood

Anemia
HIV/AIDS
Sickle Cell Disease

Other

Alcohol/Drug Use
Allergy
Cancer

FAMILY HISTORY (Circle any illness your blood relatives have had, and list the relative)

(Grandparents, Parents, Brothers, Sisters, Children, Blood Related Aunts and Uncles)

Respiratory

Asthma
Emphysema/COPD
Pneumonia
Tuberculosis

Heart

Congestive Heart Failure
Heart Attack
High Blood Pressure
Palpitations

Abdomen

Kidney Disease
Liver Disease

Nerves

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SOCIAL HISTORY

Tobacco: Yes No If yes, how much per day _____ Alcohol: Yes No If yes, how much per week _____

Recreational Drug Use: Yes No If yes, what? _____ How often? _____

Routine Exercise: Yes No If yes, how often _____ Do you always wear your seat belt? Yes No

Nutritional Assessment: # of meals per day _____ Number of servings of fruits and vegetables per day _____

Caffeine consumption per day _____ Contraceptive method _____

What do you do for your own enjoyment? (Hobbies, Leisure activities) _____

Do you feel safe at home? Yes No If no, please explain _____

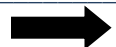
Optional: What are your religious/spiritual beliefs? _____

MEDICINES YOU ARE TAKING OR HAVE TAKEN RECENTLY:

1 _____	3 _____	5 _____
2 _____	4 _____	6 _____

ALLERGY TO ANY MEDICINE No Yes If yes, please list _____

See other side



SYSTEMS REVIEW

Circle if YES

Please circle any problems you are currently having and explain.

METABOLIC /ENDOCRINE

Weight change _____
 Warmer/Colder than others _____
 Increased sweating _____
 Neck swelling _____
 Increased thirst _____
 Increased urination _____
 Skin, Hair, Nail Change _____

HEAD, EYES, EARS, NOSE, THROAT

Headache _____
 Hearing problem _____
 Eye problem _____
 Ear pain _____
 Dizziness _____
 Nasal drainage _____
 Sore mouth/throat _____

CARDIOVASCULAR

Chest pain _____
 Fast/Irregular heartbeat _____
 Ankle swelling _____
 High blood pressure _____
 Calf pain with walking _____

RESPIRATORY

Short of breath _____
 Wheezing _____
 Cough up drainage _____
 Cough up blood _____

URINARY

Blood in urine _____
 Urinary frequency _____
 Pain/Burning with urination _____
 Empty bladder at night _____
 Bladder leakage _____

FEMALE PATIENTS

Spot or menstruate _____ Yes _____ No _____
 Every _____ days, for _____ days each period.
 Age of onset _____ Menopause _____
 Last Period _____ Last Pap smear _____
 Number of pregnancies _____ Number of children _____
 Breast changes _____
 Calcium intake _____
 Do you do breast self-exams? Yes _____ No _____

REMARKS

ALLERGIC/IMMUNOLOGIC

Allergies/Hay fever _____
 Asthma _____
 Rashes/Hives _____

GASTROINTESTINAL

Heartburn _____
 Nausea/Vomiting _____
 Trouble swallowing _____
 Abdominal pain _____
 Blood in stools _____
 Black stools _____
 Jaundice (Yellowing of Skin/Eyes) _____
 Change in bowel habit _____
 Constipation _____
 Diarrhea _____
 Belching/Gas _____
 Hemorrhoids _____

MUSCULOSKELETAL/NEURO/PSYCHIATRIC

Back pain _____
 Joint pain _____
 Stiff neck _____
 Muscle weakness/paralysis _____
 Tremor/Shakes _____
 Numbness/Tingling _____
 Convulsions _____
 Fainting _____
 Depression/Anxiety _____
 Suicide Attempts/Self-inflicted injury _____
 Stress _____
 Trouble Sleeping _____

BLOOD/LYMPHATIC/CONSTITUTIONAL

Bleeding/Bruising _____
 Anemia _____
 Enlarged glands _____
 Fever _____

MALE PATIENTS

Impotence _____
 Changes in urinary stream _____
 Scrotal lumps _____
 Last Testicular Exam _____

VACCINES

Do you have a copy of your vaccine record? Yes _____ No _____

Please list the other people in your household:

 Physician/APRN Reviewed Signature

 Date