

## New Patient Medical History Questionnaire

Today's date \_\_\_\_\_

Please complete the following questionnaire prior to your appointment with the physician. This information is very important to us for your care so please answer all the sections as accurately as possible.

**Name:** \_\_\_\_\_ **Date of Birth** \_\_\_\_\_ **Age** \_\_\_\_\_ **Race** \_\_\_\_\_

Current problem (Briefly state why you are here to see the doctor)

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### Please list your physicians

Referring Physician \_\_\_\_\_ Surgeon \_\_\_\_\_

Primary Physician \_\_\_\_\_ OB / Gyn. \_\_\_\_\_

### Medical History

**Current weight** \_\_\_\_\_ **Usual Weight** \_\_\_\_\_ **Height** \_\_\_\_\_

Date of last pneumovax immunization: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Date of last flu immunization: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Date of last tetanus immunization: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

### Current Activity Level

- Fully active; normal
- Have difficulty with strenuous activity; can do light activities (housework, office work)
- Unable to work; can care for self; out of bed or chair more than 50%
- Can only do limited self care; stay in bed or chair more than 50% of waking hours
- Cannot do self care; confined to bed or chair

Please rate your fatigue/energy level: 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

(0 = not tired, full of energy) (10 = total exhaustion)

How many hours do you sleep at night? \_\_\_\_\_ Do you nap during the day?  Yes  No

Is your appetite \_\_\_\_\_ good \_\_\_\_\_ fair \_\_\_\_\_ poor

Current weight: \_\_\_\_\_ Weight 6 months ago: \_\_\_\_\_ Normal weight: \_\_\_\_\_

1. If you currently have pain, where is it?
2. If you currently have pain, please rate your pain: 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10  
(0 = no pain) (10 = worst possible pain)
3. What are you currently doing to relieve your pain?

### Past Medical History

Please review the following list. If you have any of these conditions check  Yes or No and the approximate year of diagnosis. If you have other conditions not listed, please write them down in the space provided.

Condition / disease	Yes	No	Year	Condition / disease	Yes	No	Year
Alcoholism / Cirrhosis				Cataracts			
Anemia				Diabetes (high blood sugar)			
Arthritis				Gallbladder disease / stones			
Asthma / Emphysema				Glaucoma			
Bleeding / Blood Disorders / Clots				Crohn's disease / colitis			
Bone or spine				Heart disease			
Cancer (past)				Heart attack (MI)			
Leukemia				Hepatitis / Jaundice / Liver			
Lymphoma				High blood pressure			

Condition / disease	Yes	No	Year	Condition / disease	Yes	No	Year
HIV positive / AIDS				Tuberculosis			
Lung disease				Ulcers / stomach pain			
Prostate disease				Other: Significant illness for			
Seizures / epilepsy				which you have taken medicine			
Stroke(s)				and/or seen a physician.			
Thyroid disease							

(Please list all hospitalizations, and surgeries with the approximate date)

Hospitalizations and/or surgeries	Date	Hospitalizations and/or surgeries	Date

**Transfusion History** Have you ever had a blood transfusion? (circle one) Yes No When? \_\_\_\_\_

**Allergies** (List all medication / health products with which you have had a bad reaction and what type of reaction occurred).

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Medications** (List all medication names including non-prescription medications, vitamins, herbs, or supplements.) Please include the dosage, and how many you take daily (example: Lasix 20 mg 1 tablet daily)

1.	6.
2.	7.
3.	8.
4.	9.
5.	10.

**Female Patients Only** Obstetrical and Gynecological History

Age at start of periods _____ Date of last period _____ Date of last pelvic exam _____
Date of last PAP smear _____ Name of doctor performing exam _____
Age at first pregnancy _____ Number of pregnancies _____ Number of live birth _____
Are you presently taking birth control pills or other hormones? (Circle one) Yes No How many years? _____
Name of medication(s) _____
What do you currently use for birth control? _____
Have you gone through menopause? (Circle one) Yes No What age? _____
Have you had your uterus and ovaries removed? (Circle one) Yes No Date _____
Do you have abnormal vaginal bleeding or bleeding after intercourse? (Circle one) Yes No
Do you perform monthly self breast exams? (Circle one) Yes No
Have you had a mammogram? (Circle one) Yes No Date _____ Location _____

**Social History**

1. Marital status **(circle one)** Married / Single / Separated / Divorced / Widowed Do you live alone? **(circle one)** Yes No
2. What is your occupation? \_\_\_\_\_ Are you retired? **(circle one)** Yes No
3. Do you use tobacco products? **(circle one)** Yes No How many years? \_\_\_\_\_  
 Have you stopped? **(circle one)** Yes No When? \_\_\_\_\_  
 What did/do you use? **(circle one)** Cigarettes (# of packs / day) \_\_\_\_\_ Cigars Pipe Chewing tobacco
4. Do you use drugs or alcohol? **(circle one)** Yes No  
 If you drink alcohol products, what do you drink and how many per day? \_\_\_\_\_  
 If you use recreational (street) drugs, what do you use and how often? \_\_\_\_\_
5. Have you ever been exposed to radiation or asbestos? **(circle one)** Yes No
6. Have you ever received treatment for emotional or mental problems? **(circle one)** Yes No  
 What type of treatment did you receive? \_\_\_\_\_
7. Do you have a living will? **(circle one)** Yes No *Please provide a copy for our records.*

**Family History**

Do you have anyone in your immediate family who has been diagnosed with Heart disease, Diabetes, Arthritis, Kidney disease, Blood disorder, Blood clots, etc.? Yes No Please list below the family member affected and what their condition was?

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**Family Health Questionnaire For Cancer**

Please indicate age at diagnosis and if this cancer was the cause of their death. Yes No

	Breast	Endometrial	Ovarian	Lung	Colon	Prostate	Pancreatic	Other
<b>First Degree Relatives</b>								
Children								
Mother								
Father								
Sister(s)								
Brother(s)								
<b>Mother's Side</b>								
Grandmother								
Grandfather								
Aunt(s)								
Uncle(s)								
Cousin(s)								
<b>Father's Side</b>								
Grandmother								
Grandfather								
Aunt(s)								
Uncle(s)								
Cousin(s)								

## Review of Systems

Review the following and Check  **C for current problem** or **P for past problem** in space provided.  
 Leave the spaces blank if you have never had any of the following.

<b>Problem</b>	<b>C</b>	<b>P</b>	<b>Problem</b>	<b>C</b>	<b>P</b>
Pain - Where? _____			Muscle pain or weakness		
Fatigue / weakness			Numbness or tingling		
Fevers / chills / night sweats			Difficulty walking		
Lump(s) or swelling			Decreased appetite		
Rashes / Moles			Abdominal pain / Swelling		
Bruising easily			Black or bloody stools		
Bleeding or Blood clotting			Bloating		
Sleeping disturbance / insomnia / too much sleep			Constipation		
Weight loss or gain (how much?) _____			Diarrhea		
Changes in Breast / Breast Lumps			Increased gas		
Headaches			Nausea and/or vomiting		
Vision changes			Needing to urinate frequently		
Seizures / epilepsy			Bladder pain or pain with urination		
Memory loss			Bleeding with urination		
Dental problems / Hoarseness			Lump(s) in testicles		
Mouth sores			Loss of sexual potency		
Sinus trouble			Hot flashes		
Chest pain / Pressure			Vaginal discharge / Odor / Bleeding		
Ankle swelling			Pain with intercourse		
Rapid heartbeat			Feel Depressed		
Cough			Loss of interest in usual activities		
Cough up blood			Recent infections or allergies		
Difficulty swallowing			Other:		
Difficulty breathing					