NEW PATIENT HEALTH QUESTIONAIRE

Thank you for taking your time in completing this patient evaluation form.
This information will help us take better care of you!

Name: ____________________________ DOB_______________Today's Date_________________

Medical History: Please circle any medical problems you have (also indicate date of diagnosis):

Asthma	Cancer, Ovaries	Heart Problems:____________
Blood Pressure Problems	Cancer, Prostate	Kidney disease
Blood/Bleeding Disorders	Cancer, Uterus	Liver disease
Cancer, Breast	Cholesterol Problems	Osteoporosis
Cancer, Colon	Depression	Seizures
Cancer, Lung	Diabetes or High Blood Sugar	Strokes
Cancer, Other:____________	Emphysema	Thyroid Problems

Please list any other medical problems you are aware of (including date of diagnosis):

Surgical History: Please list all surgeries (indicate type of surgery and date):

Medications: Please list all medications and suppliments, both prescription and over-the-counter (including name, dose, and when first prescribed):

Allergies: Please list any allergies to medications or otherwise (including reaction):

Family History: Please circle any of the following conditions that are present in your family:

Asthma	Cancer, Ovaries	Heart Problems:____________
Blood Pressure Problems	Cancer, Prostate	Kidney disease
Blood/Bleeding Disorders	Cancer, Uterus	Liver disease
Cancer, Breast	Cholesterol Problems	Osteoporosis
Cancer, Colon	Depression	Seizures
Cancer, Lung	Diabetes or High Blood Sugar	Strokes
Cancer, Other:____________	Emphysema	Thyroid Problems

Social History:

Do you smoke? **Yes** (amount per day ________) **No** - Have you ever? No Yes (quit date ________)

Do you drink alcohol? **Yes** (amount ________) **No** - Have you ever? No Yes (quit date ________)

Marital status: married single divorced separated widowed

Number of children: ____

Occupation: ___________________________ Retired

Have you ever had a blood transfusion? No Yes (date ______)

Have you ever used illicit drugs? No Yes (specify type: _______________________________________)

Any known exposure to HIV or hepatitis? No Yes

Exercise: None Daily Weekly Specify Routine: __________________________________

Do you have a living will or advanced directive? Yes No (*Please provide a copy if you do*)

Health Maintenance:

Please check any of the following that you have had in the past, and note date and result:

complete physical
chest X-ray
EKG
eye exam
cholesterol check
thyroid test
cardiac stress test
colonoscopy or flex/sig

For men:

prostate blood test (PSA)
prostate exam

For women:

mammogram
PAP smear
bone density test

Last menstrual period: ________________________

Regarding Birth Control:

Abstinent	Hysterectomy	Tubal Ligation
Barrier(i.e. condoms)	IUD	Vasectomy of Partner
Birth Control Medication	Menopause	

Immunizations:

When was your last flu shot? _____________________

Have you ever had a pneumonia shot? ______________ If yes, list when: __________________

When was your last tetanus booster? ________________

When was your last diphtheria booster? _____________

Review of systems:
Please circle symptoms which you are **currently** experiencing:

Systemic: fever fatigue weight loss night sweats

HEENT: vision changes sinus problems

Cardiac: chest pain shortness of breath with activity irregular heartbeat

Pulmonary: shortness of breath cough

GI: abdominal pain nausea/vomiting heartburn diarrhea constipation rectal bleeding

Endocrine: weight gain increased thirst intolerance of heat intolerance of cold

Hematology: anemia bleeding swollen glands

Rheumatology: joint pain joint swelling

GU: painful urination blood in the urine urine slow to start increased urination

GYN: unusual vaginal bleeding unusual vaginal discharge

Neurology: seizures dizziness severe headaches unusual numbness/tingling weakness of arm/leg

Dermatology: rash changes in moles unusual skin lesions

Psych: depression anxiety chronic insomnia

Please list other symptoms you are concerned about: