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

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

EARS

_______ decreased hearing
_______ ear pain
_______ ringing
_______ Other

PULMONARY

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

INTEGUMENTARY

_______ rashes
_______ hives
_______ Other

HEMOTOLOGICAL

_______ fatigue
_______ easy bruising
_______ excessive bleeding
_______ Other

Patient Name (print) ____ Date: ________________

________ date/bone density ________ affects work life
________ Other ________ Other

CONTINUED ---- Section 2: REVIEW OF SYSTEMS

PSYCOLOGICAL/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

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: ________________

________ cold, numb feet
________ Other

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 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

BREASTS PROBLEMS

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

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

________ Other

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

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

Patient Name (print) ____ Date: ________________

________ Other

________ dementia (e.g. Alzheimer's)

________ Other

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 A / D	Current Age or age at death	Heart Disease	Cancer Type	Stroke	High BP or Cholesterol	Diabetes	Other
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: ____________________

	MEDIATION	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 Signature Date

Patient Name (print) ____________________________________ Date: _______________