New Patient Health Questionnaire

Name: ______________________________

Date of Birth: ______________________________

Date completed: ______________________________

Dear Patient,

In order to offer optimal care for you, we need to understand your complete health status and health history. With this goal in mind, we appreciate you spending ten to twenty minutes completing this comprehensive health questionnaire.

Review of Systems

For the **Review of Systems** section, please indicate "Yes" if you are currently experiencing the symptom or if you have experienced the symptom within the past three months.

Please fill in the appropriate bubble completely. For example .... ● Yes ○ No

General

Chills .... ○ Yes ○ No

Fever .... ○ Yes ○ No

Night sweats .... ○ Yes ○ No

Sleep disturbance .... ○ Yes ○ No

Frequent or persistent headaches .... ○ Yes ○ No

Change in appetite .... ○ Yes ○ No

Weight gain .... ○ Yes ○ No

Weight loss .... ○ Yes ○ No

Lightheadedness .... ○ Yes ○ No

Fatigue .... ○ Yes ○ No

Skin

Acne .... ○ Yes ○ No

Rash .... ○ Yes ○ No

New skin moles .... ○ Yes ○ No

Dry skin .... ○ Yes ○ No

Discoloration .... ○ Yes ○ No

Eczema .... ○ Yes ○ No

Behavioral

Anxiety .... ○ Yes ○ No

Depression .... ○ Yes ○ No

Patient Name: ______________________________

Mental or Physical abuse .... O Yes O No

Suicidal thoughts .... O Yes O No

Auditory/visual hallucinations .... O Yes O No

Eating disorder .... O Yes O No

Neurologic

Numbness or tingling in hands or feet .. O Yes O No

Memory loss .... O Yes O No

Fainting .... O Yes O No

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Difficulty balancing / frequent falls .... O Yes O No

Tremor .... O Yes O No

Seizures .... O Yes O No

Pain .... O Yes O No

Dizziness .... O Yes O No

Endocrine

Heat intolerance .... O Yes O No

Excessive thirst .... O Yes O No

Cold intolerance .... O Yes O No

Frequent urination .... O Yes O No

Eyes

Flashes of light in visual field .... O Yes O No

Decreased vision .... O Yes O No

Floaters in visual field .... O Yes O No

Blurred vision .... O Yes O No

Elevated pressure .... O Yes O No

Dry eyes .... O Yes O No

Ear / Nose / Throat

Decreased hearing .... O Yes O No

Dry mouth .... O Yes O No

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Patient Name: ________________________________

Ringing in the ears .... O Yes O No

Ear pain.. O Yes O No

Sinus pain or infection.......................... O Yes O No

Difficulty swallowing .... O Yes O No

Sore throat .... O Yes O No

Swollen glands.................. O Yes O No

Allergy

Itching .... O Yes O No

Hives .... O Yes O No

Sneezing .... O Yes O No

Watery eyes .... O Yes O No

Respiratory

Wheezing .... O Yes O No

Shortness of breath at rest.................... O Yes O No

Shortness of breath with exertion .... O Yes O No

Dry cough.......................... O Yes O No

Productive cough .... O Yes O No

Bloody cough .... O Yes O No

Cardiovascular

Shortness of breath when lying flat....... O Yes O No

Irregular heartbeat .... O Yes O No

Palpitations .... O Yes O No

Chest pain at rest............. O Yes O No

Chest pain with exertion ... O Yes O No

Ankle swelling .... O Yes O No

Peripheral Vascular

Decreased sensation in hands or feet .. O Yes O No

Cold hands or feet................................ O Yes O No

Foot or leg ulcers .... O Yes O No

Leg pain when walking ..... O Yes O No

Breast

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Breast pain.. O Yes O No

Nipple discharge .... O Yes O No

Nipple retraction / inversion .... O Yes O No

Skin redness .... O Yes O No

Enlarged lymph nodes ...... O Yes O No

Breast lump....................... O Yes O No

Gynecologic

Hot flashes.. O Yes O No

Vaginal discharge / itching .... O Yes O No

Vaginal bleeding between periods .... O Yes O No

Painful intercourse .... O Yes O No

Irregular periods............... O Yes O No

Missed periods................. O Yes O No

Heavy periods.................. O Yes O No

Painful periods .... O Yes O No

Gastrointestinal

Heartburn / indigestion......................... O Yes O No

Nausea.. O Yes O No

Abdominal pain .... O Yes O No

Vomiting .... O Yes O No

Constipation .... O Yes O No

Diarrhea .... O Yes O No

Blood in stool .... O Yes O No

Rectal bleeding................ O Yes O No

Urinary

Urinary incontinence .... O Yes O No

Change in force of stream.................... O Yes O No

Blood in urine................... O Yes O No

Painful urination .... O Yes O No

Hematology (Blood)

Easy bruising .... O Yes O No

Prolonged bleeding .... O Yes O No

Musculoskeletal

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Painful joints.. O Yes O No

Swollen joints .... O Yes O No

Leg cramps .... O Yes O No

Muscle aches.................... O Yes O No

OB/Gyn History

Age at first menstrual period ....__________

Date of last menstrual period ....__________

Birth control pills used.......................... O Yes O No

If yes, number of years ....__________

Hormone replacement therapy used..... O Yes O No

If yes, number of years ....__________

Total pregnancies ....________

Number of live births ....________

Number of miscarriages ....________

Number of abortions...................________

Number of C-Sections................________

Number of ectopic pregnancies ..________

Age when first child was born .....________

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Medical History

For **Medical History**, please indicate if you have ever been diagnosed with or treated for any of the following conditions.

	Yes		Yes
Asthma	O	Carpal tunnel	O
Bronchitis	O	Sleep apnea	O
Hyperthyroidism	O	Kidney stones	O
Hypothyroidism	O	Kidney disease	O
Tuberculosis	O	Autoimmune disorder	O
Thrombosis / Blood Clots	O	HIV/AIDS	O
Varicose veins	O	Lupus	O
Diabetes, type I (insulin dependent)	O	Hepatitis B	O
Diabetes, type II (non-insulin dependent)	O	Hepatitis C	O
Heart murmur	O	Mitral valve prolapse	O
Hypercholesterolemia / high cholesterol	O	Atrial fibrillation	O
Hypertension / high blood pressure	O	Congestive heart failure	O
Coronary artery disease / angina	O	Stroke	O
Abnormal pap smear	O	Ovarian mass	O
Abnormal uterine bleeding	O	Pelvic organ prolapse	O
Arthritis	O	Osteoporosis	O
Rheumatoid arthritis	O	Gout	O
Neurologic disorder	O	Multiple sclerosis	O
Anxiety disorder / panic attacks p	O	Alcohol abuse	O
Schizophrenia	O	Drug abuse	O
Depression / mania / bipolar disorder	O		

Other diagnosed conditions:

Preventive Health (indicate date of last screening)

Date (Mo/Yr) **Date (Mo/Yr)**

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Pap smear........................... ____________

Mammogram....................... ____________

Colonoscopy .... ____________

Bone Density........................ ____________

Cholesterol measurement.... ____________

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Patient Name: ______________________________

Social History

Alcohol Consumption

Frequency .... O Less than 1 drink per week O 2-3 drinks per week
O 1 drink per day O 2 or 3 per day O More than 3 per day

Tobacco Use

Do you smoke? ....O Yes O No Cigarettes per day? ________

Hospitalizations and Surgeries

Month / Year	Reason

Allergies (including lidocaine, other topical anesthetics, horse serum)

Substance	Reaction

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Current Medications (including over-the-counter meds, vitamins, nutritional supplements)

Name	Strength	Qty	Frequency	Start Date	Stop Date

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Family Medical History

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Family Members		Status (**A** / **D** / **U**) **A**live, **D**eceased, **U**nknown	Family History Age at which member was diagnosed											
			Breast cancer	**Ovarian cancer**	**Uterine cancer**	**Colon cancer**	**Prostate Cancer**	**Stomach cancer**	**Pancreatic cancer**	**Melanoma**	**Heart disease**	**High blood pressure**	**Diabetes**	**Other**
Example		*A*	*62*									*51*		*Lymphoma (68)*
Paternal Family	Father			n/a	n/a									
	Grandfather			n/a	n/a									
	Grandmother						n/a							
	Aunt						n/a							
	Uncle			n/a	n/a									
Maternal Family	Mother						n/a							
	Grandfather			n/a	n/a									
	Grandmother						n/a							
	Aunt						n/a							
	Uncle			n/a	n/a									
Personal	Self						n/a							
	Sister						n/a							
	Brother			n/a	n/a									

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