

New Patient Medical Questionnaire

*This is a lengthy form and we apologize for its length.
It is important for you to carefully complete it, for it will make it easier for us to provide the best care for you.*

Name _____ SS # _____

Birthdate _____ Age _____ Hgt _____ Wgt _____ Sex _____

Address _____ Chart Number _____

Referring Doctor and Address _____

Doctor You Are Seeing Today _____ Today's Date _____

Do you have a living will? yes _____ no _____ Do you have an advanced directive? yes _____ no _____

If you have a living will or an advanced directive please provide us with a copy for your chart.

Present Problem

1. Chief complaint – why are you seeing the Doctor today? Please describe your symptoms and length of time you have had them

2. Have you had this problem before? _____ How long? _____

3. Have you had any treatment for this problem? _____

What kind of treatment? _____

For how long? _____

Who treated you? _____

4. Were you injured at work? _____

Date of injury? _____ Did you report it? _____ Date you last worked _____

Details of injury _____

5. Are your symptoms accident related? _____ Date of accident _____

6. Is there a law suit in this accident/Injury? _____

7. Job _____

8. Have you had physical therapy? _____

9. Have you had epidural steroid injections? _____

Past History

10. Operations – Please list type, date, and Doctor _____

11. Hospitalizations (Not operations) – Please list reason, year, and Doctor _____

12. Allergies to medicines _____

13. Medicines you are presently taking and the dosage

_____	_____	_____
_____	_____	_____
_____	_____	_____

14. Are you DIABETIC? _____

15. Do you take COUMADIN? _____

In the event a MRI is needed – Do you have a pacemaker? _____

Do you have aneurysm clips in your brain? _____

Are you claustrophobic? _____

Review of Systems If you answer yes, please elaborate

HEENT

___ Frequent headaches _____

___ Dizziness _____

___ Falling out spells _____

___ Ringing in your ears _____

___ Trouble hearing _____

___ Blurred vision or double vision _____

___ Glaucoma _____

___ Frequent nosebleeds _____

___ Difficulty swallowing _____

___ Hoarseness _____

___ Change in your voice _____

CARDIORESPIRATORY

- _____ Chest pain _____
- _____ Heart attack _____
- _____ High blood pressure/Hypertension _____
- _____ Shortness of breath _____
- _____ Pulmonary embolus _____
- _____ Have to prop yourself up to breathe at night _____
- _____ Wheezing or asthma _____
- _____ Coughing up blood _____
- _____ Chest pain with exertion _____
- _____ Arm, neck, or jaw pain with exertion _____
- _____ Feel your heart pound, skip or race _____
- _____ Had a heart murmur _____
- _____ Ankle swelling _____
- _____ Phlebitis _____

GASTROINTESTINAL

- _____ Change in weight or appetite _____
- _____ Indigestion _____
- _____ Nausea _____
- _____ Frequent vomiting _____
- _____ Abdominal pain _____
- _____ Black, tarry stools or blood in stools _____
- _____ Diarrhea _____
- _____ Hepatitis _____

GENITOURINARY

- _____ Difficulty voiding _____
- _____ Difficulty controlling urine _____
- _____ Getting up at night often to void _____
- _____ Blood in your urine _____
- _____ Impotence _____
- _____ Pain or problems during sexual intercourse _____

NEUROMUSCULAR

- _____ Frequent headaches _____
- _____ Seizures _____
- _____ Any episodes of numbness or paralysis _____
- _____ Any episodes of visual loss _____
- _____ Stroke _____

- ___ Migraine headaches _____
- ___ Frequent episodes of joint pain or swelling _____
- ___ Severe back pain _____
- ___ Calf of leg pain with walking _____

GENERAL

- ___ Bleeds or bruises easily _____
- ___ Any difficulty with operations or dental work _____
- ___ Any change in mood _____
- ___ Trouble sleeping _____
- ___ Experienced any new major stresses _____
- ___ Lack of energy _____
- ___ Any difficulty with alcohol or drugs _____
- ___ Thought you should cut down on your drinking of alcohol _____
- ___ Feeling down, depressed or hopeless _____
- ___ Any changes in your skin – rashes, itching _____

Family History Have any of your relatives had...

	Father	Mother	Brother	Sister	Aunt / Uncle	Grand parent	Child	Comments
Heart disease	___	___	___	___	___	___	___	_____
High blood pressure	___	___	___	___	___	___	___	_____
Stroke	___	___	___	___	___	___	___	_____
Kidney disease	___	___	___	___	___	___	___	_____
Breast cancer	___	___	___	___	___	___	___	_____
Prostate cancer	___	___	___	___	___	___	___	_____
Colon cancer	___	___	___	___	___	___	___	_____
Psychiatric illness	___	___	___	___	___	___	___	_____
Anemia	___	___	___	___	___	___	___	_____

Social History

- Do you use tobacco? ___ How much and how long? _____
- Do you use alcohol? ___ How much and how long? _____
- Education? _____
- Vocation? _____ Still working? _____
- Are you exposed to toxins? _____

Physician's Signature _____ Date _____