

Form 06003: New Patient Medical History Questionnaire

NAME: _____ AGE: _____ DATE: _____

PHYSICIANS you are seeing today: _____

PHYSICIANS you have seen in the past: _____

NAME, LOCATION, PHONE AND FAX NUMBER OF YOUR PREFERRED PHARMACY _____

CURRENT MEDICAL PROBLEMS: _____

OTHER CONCERNS you would like to discuss with the physician: _____

List all CURRENT PRESCRIPTION MEDICINES (include dosage, reason you take it, who prescribed it):

List all OVER-THE-COUNTER MEDICINES, vitamins, and food supplements that you take: _____

ALLERGIES: _____

SENSITIVITIES: _____

List SURGERIES you have had (include year, surgeon, hospital): _____

Describe HOSPITALIZATIONS/ILLNESSES not included above (include year, hospital): _____

Have you had (circle):	migraines	hepatitis	mono	ulcer
bleeding problem	blood clots	head injury	drug addiction	gallstones
tuberculosis	STDs	seizures	memory trouble	arthritis
psoriasis	heart murmur	rheumatic fever	polio	shingles
alcoholism	depression	mental illness	gout	hemorrhoids
hearing trouble	vision trouble	other	_____	_____

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WOMEN

Age at first period _____ Date of last normal period _____ No. of pregnancies _____

No. of live births _____ No. of children living with you _____ Birth control method _____

Date of last Pap _____ Done where _____

Date of last mammogram _____ Done where _____

Do you have (circle):

irregular periods	bad menstrual cramps	heavy periods	pelvic pain	infertility
female trouble	hot flashes	vaginal dryness	vaginal discharge	vaginal odor
vaginal itching	PMS	breast problems	abnormal mammogram	abnormal Pap smear

ALL

Who in your *family* has/had (circle if cause of death and write age of death)

heart disease _____ genetic disorder _____

diabetes _____ cancer _____

thyroid disease _____ alcoholism _____

mental illness _____ arthritis _____

glaucoma _____ asthma _____

allergies _____ stomach problems _____

tuberculosis _____ high blood pressure _____

List any other diseases that run in your family and specify your relationship to each family member listed. _____

When was your last:

tetanus shot _____ flu shot _____ EKG _____

TB test _____ HIV test _____ sigmoidoscopy _____

chest x-ray _____ pneumonia shot _____ hepatitis vaccine _____

rectal exam _____ blood test _____

Who lives in your household? _____

Where do/did you work? _____

Describe your education/upbringing, etc _____

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How much do you weigh? _____ How much would you like to weigh? _____ Heaviest weight _____

Do/did you EXERCISE? _____ How much? _____ hrs/wk No. of years? _____ Year you QUIT _____

Do/did you SMOKE? _____ How much? _____ packs/day No. of years _____ Year you QUIT _____

Do/did you DRINK alcohol? _____ How much? _____ drinks/week No. of years _____

Year you QUIT _____ Previous or current problem with alcohol? _____ AA? _____

Do/did you use (circle): caffeine Nutrasweet marijuana cocaine chewing tobacco diet pills

Do you wear seat belts? _____ Ride a motorcycle/bicycle? _____ Do you wear sunscreen? _____

Describe your diet. _____

Circle those that describe your general condition: Feeling well, weight gain, weight loss, persistent infections, appetite loss, chills, dietary changes, excessive crying, fatigue, fever medication changes, night sweats, obesity

Circle those that describe any changes involving your head, eyes, ears, nose, or throat: Blurred vision, headache, head injury, wear glasses/contacts, color blindness, decreased night vision, double vision, excessive tearing, eye pain, eye redness, visual disturbance, visual loss, hearing loss, deafness, ear infection, ear discharge, ear pain, earache, ringing in the ears (tinnitus), spinning sensation (vertigo), nosebleeds, frequent cold, nasal congestion, seasonal allergies, rhinitis, sinus pain, bleeding gums, hoarseness, oral sores, sore throat, voice changes

Circle those that describe any respiratory problems you are having: Cough, decreased exercise tolerance, snoring, difficulty breathing (dyspnea), coughing up blood (hemoptysis), Phlegm/sputum production, wheezing

Circle those that describe any cardiovascular problems you are having: Fainting, chest pain, calf cramps (claudication), difficulty breathing on exertion, retaining fluid (edema), irregular heart beat, abnormal blood pressure, elevated blood pressure, difficulty breathing when lying down (orthopnea), rapid heartbeat (palpitations), waking up gasping for breath (PND), leg pain or swelling, general shortness of breath

Circle those that describe any MALE urinary problems you are having: Blood in urine, change in bladder habits, change in urine stream, urethral discharge, pain or burning when urinating (dysuria), flank pain, increased frequency, difficulty starting urine stream (hesitancy), impotence, incontinence

Circle those that describe any FEMALE genitourinary problems you are having: Uterine contractions, urinary complaints, vaginal dryness, vaginal itching/burning, vaginal discharge, lack of periods (menstruation), blood in urine, change in bladder habits, change in urine stream, urethral discharge, painful periods, painful sex, pain or burning when urinating (dysuria), heavy periods (menstrual bleeding), bleeding between periods or after menopause, flank pain, increased urinary frequency, difficulty starting urine stream (hesitancy), incontinence, urinating at night, pelvic pain, excessive urinating (polyuria), inability to urinate (urinary retention)

Circle those that describe any neurologic problems you are having: Numbness, trouble walking, auras, decreased memory, difficulty speaking, dizziness, fasciculations, fainting, headache, incontinence of stool, incontinence of urine, incoordination, seizures, spinning sensation, stroke, tremor, unusual sensations (burning, tingling), visual changes, weakness overall, weakness in the limbs/extremities

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Circle those that describe any endocrine problems you are having: Appetite changes, cold intolerance, excessive thirst, excessive urination, hair changes, heat intolerance, hot flashes, libido change, sexual dysfunction, thyroid problems

Describe your skin problems: Bruising, change in warts/moles, clamminess, dryness, excessive sweating, abnormal hair growth, hair loss, hives, itching, nail changes, new lesions, paleness, rash, skin color changes, ulcers

Circle those that describe any neck problems you are having: Neck mass, neck pain, neck stiffness, swollen glands

Circle those that describe any breast problems you are having: Breast mass, breast pain, breast swelling, nipple discharge, nipple pain, skin changes

Circle those that describe any gastrointestinal problems you are having: diarrhea, gas, hemorrhoids, abdominal mass, abdominal pain, black stool, bloody stool, change in bowel habits, constipation, difficulty swallowing/dysphagia, food intolerance, vomiting blood (hematemesis), heartburn, indigestion, jaundice (yellow skin), nausea, vomiting

Describe sexual concerns: Decreased sex drive, decreased sexual enjoyment, decreased sexual performance

Circle those that describe any musculoskeletal problems you are having: Leg cramps, back pain, calf pain (claudication), decreased range of motion, fasciculations, joint pain, joint redness, joint stiffness, joint swelling, muscle shrinking (atrophy), muscle cramps, muscle pain, muscle weakness, swelling of the extremities (arms/hands or legs/feet)

Circle those that describe any psychiatric problems you are having: Anxiety, change in sleep pattern, delusions, depression, early awakening, fearful, hallucinations, excessive sleeping (hypersomnia), inability to concentrate, mood changes, insomnia, panic attacks, suicidal ideas, suicidal planning, feels safe at home, frequent crying

Circle those that describe any hematologic problems you are having: Excessive bleeding, anemia, blood clots, easy bruising, enlarged lymph nodes, nosebleeds, pinpoint hemorrhages, spontaneous bleeding

Anything else? _____

Please sign and date: _____