BARNES-JEWISH Hospital
BJC HealthCare

Washington University in St. Louis
SCHOOL OF MEDICINE

NAME: _____

D.O.B.: _____

PATIENT IDENTIFICATION

NEW PATIENT QUESTIONNAIRE
– PLEASE COMPLETE ALL PAGES –

Please check (✔) the box(es) (☐) that best describes the answer to each question below and fill in the blank(s) as needed.

Person Who Completed this Form: ☐ Self Other: | Today's Date:

CONTACT INFORMATION

Email address:

Home phone number: | Cell phone number:

Patient work number: | May we call you at work? ☐ Yes ☐ No

May we leave information about your appointment with your family? ☐ Yes ☐ No

On answering machine? ☐ Yes ☐ No

If we cannot reach you, whom should we call?

How are you related? | Phone #:

Why are you being seen today? | Doctor who sent you here:

PAST MEDICAL CONDITIONS – Please check all that apply or have applied in the past.

☐ Atrial Fibrillation	☐ Cancer	☐ High blood pressure	☐ Prostate problem
☐ Alcoholism	☐ Congestive Heart Failure	☐ High cholesterol	☐ Psychiatric problem
☐ Anemia	☐ Diabetes ☐ type I ☐ type II	☐ HIV positive	☐ Stroke
☐ Anxiety	☐ Depression	☐ Kidney problems	☐ Thyroid problem
☐ Arthritis/Gout	☐ Emphysema	☐ Liver problems	☐ Tuberculosis
☐ Asthma	☐ Epilepsy	☐ Mononucleosis	☐ Ulcers
☐ Bleeding disorders	☐ Hepatitis	☐ Osteoporosis	Other: _____
☐ Bronchitis	☐ Herpes	☐ Pneumonia	

DATE OF SURGERY	TYPE OF SURGERY	DOCTOR	HOSPITAL WHERE PERFORMED

Have you ever had any type of blood transfusion? ☐ Yes ☐ No

Have you had radiation treatment before for any reason? ☐ Yes ☐ No | When? | Where?

SOCIAL HISTORY

What type of work did/do you do? ☐ Retired

Marital Status: ☐ single ☐ married ☐ divorced ☐ widowed ☐ life partner

Number of Children:

Do you live at home: ☐ Yes ☐ No ☐ alone ☐ assisted living ☐ nursing home

How far do you live from this clinic? How will you travel to the hospital/clinic?

Have you ever smoked? ☐ Yes ☐ No If yes, # packs per day for # years. Date Quit?

Do you drink alcohol? ☐ Yes ☐ No If yes, ☐ beer ☐ wine ☐ spirits

Number of drinks/week: If you used to drink, when did you stop? / /

Do you use drugs to get high? ☐ Yes ☐ No If yes, which drugs?

EDUCATIONAL ASSESSMENT

Preferred Language: Highest grade level completed: Degree:

Do you need an interpreter? ☐ Yes ☐ No

DO NOT WRITE BELOW THIS LINE

BJ 5-3343-1750

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FAMILY HISTORY – Please list all family members alive and deceased.

RELATION	AGE	CANCER HISTORY	Age at Diagnosis	IF DECEASED, AGE & CAUSE OF DEATH
Father				
Mother				
Brother(s) #				
Sister(s) #				
Children				
Grandmother on your Mother's side				
Grandfather on your Mother's side				
Grandmother on your Father's side				
Grandfather on your Father's side				
Other Relative with Cancer				

SYMPTOMS – Check symptoms you currently have.

GENERAL
- ☐ Chills ☐ Night sweats
- ☐ Fever ☐ Tiredness
- ☐ Weakness
- ☐ Lack of appetite
- ☐ Weight gain
- ☐ Weight loss

GENITOURINARY
- ☐ Excessive urination
- ☐ Difficulty in starting stream
- ☐ Urinary dribbling/incontinence
- ☐ Kidney/Bladder Infections
- ☐ Blood in urine
- ☐ Night time urination
- ☐ Pain or burning with urination
- ☐ Urgency in urination

MEN ONLY
- ☐ Erection difficulties
- ☐ Impotence
- ☐ Lump in testicles
- ☐ Penis discharge
- ☐ Sore on penis

WOMEN ONLY
- ☐ Vaginal discharge/itching
- ☐ Painful intercourse
- ☐ Bleeding between periods
- ☐ Extreme menstrual pain
- ☐ Abnormal Pap smear
- ☐ Hot flashes/night sweats
- ☐ Breast lump
- ☐ Nipple discharge
- ☐ Breast pain

SKIN
- ☐ Bruising
- ☐ Changes in moles
- ☐ Changes in hair texture
- ☐ Changes in nail texture
- ☐ Changes in skin color
- ☐ Extreme dryness
- ☐ Eczema ☐ Hives
- ☐ Lumps ☐ Rashes

EYES, EARS, NOSE, THROAT
- ☐ Blurred vision
- ☐ Crossed eyes
- ☐ Decreased ability to see
- ☐ Double vision
- ☐ Eye pain
- ☐ Earache
- ☐ Ear drainage
- ☐ Ringing in ears
- ☐ Nosebleeds
- ☐ Runny nose
- ☐ Stuffy nose
- ☐ Post-nasal drip
- ☐ Sinus problems
- ☐ Sneezing
- ☐ Hay fever
- ☐ Hoarseness
- ☐ Sore throat
- ☐ Difficulty swallowing
- ☐ Pain with swallowing
- ☐ Dentures
- ☐ Dental problems

ENDOCRINE
- ☐ Excessive hunger
- ☐ Excessive thirst
- ☐ Excessive urination
- ☐ Heat intolerance
- ☐ Cold intolerance
- ☐ Thyroid problem
- ☐ High sugar ☐ Low sugar
- ☐ Diabetes

MUSCULOSKELETAL
- ☐ Back pain ☐ Joint aches
- ☐ Joint stiffness/swelling
- ☐ Redness of any joint
- ☐ Muscle aches
- ☐ Pain down back of legs
- ☐ Weakness

GASTROINTESTINAL
- ☐ Loss of appetite
- ☐ Indigestion
- ☐ Stomach pain
- ☐ Nausea/vomiting
- ☐ Vomiting blood
- ☐ Bloating
- ☐ Constipation
- ☐ Hemorrhoids
- ☐ Black stools
- ☐ Change in stool color
- ☐ Change in bowel habits
- ☐ Rectal bleeding
- ☐ Diarrhea
- ☐ Laxative use
- ☐ Excessive belching

CARDIOVASCULAR
- ☐ Heart palpitations
- ☐ Irregular heart beat
- ☐ Chest pain at rest
- ☐ Chest pain with exertion
- ☐ Wake up at night short of breath
- ☐ Sleep with 2 or more pillows
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Poor circulation
- ☐ Swelling of ankles/legs
- ☐ Varicose veins

PSYCHIATRIC
- ☐ Anxiety
- ☐ Depression
- ☐ Difficulty in going to sleep
- ☐ Loss of sleep
- ☐ Early morning awakening
- ☐ Difficulty with memory
- ☐ Difficulty with thinking or problem solving.

NEUROLOGIC
- ☐ Headache
- ☐ Dizziness
- ☐ Fainting
- ☐ Blackouts
- ☐ Difficulty in speaking
- ☐ Loss of balance
- ☐ Loss of coordination
- ☐ Loss of sensation
- ☐ Numbness
- ☐ Paralysis or weakness of limbs
- ☐ Seizures

RESPIRATORY
- ☐ Asthma
- ☐ Wheezing
- ☐ Bronchitis
- ☐ Pneumonia
- ☐ Dry cough
- ☐ Cough up phlegm
- ☐ Cough up blood
- ☐ Pain in chest when you cough, sneeze or move
- ☐ Shortness of breath at rest
- ☐ Shortness of breath with exertion

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STAYING HEALTHY

Have you had a flu shot?	☐ No ☐ Yes	When: / /
Have you had a pneumonia shot?	☐ No ☐ Yes	When: / /
Have you had a sigmoidoscopy/colonoscopy?	☐ No ☐ Yes	When: / /
Do you exercise on a regular basis?	☐ No ☐ Yes	How often:
Do you wear glasses?	☐ No ☐ Yes	Date of last eye doctor visit?

MALE HISTORY ☐ N/A

Do you have regular prostate exams?	☐ No ☐ Yes	When: / /
Do you have regular PSA tests?	☐ No ☐ Yes	When: / /
Do you do regular testicular exams on yourself?	☐ No ☐ Yes	When: / /

FEMALE HISTORY ☐ N/A

Age that you started having periods:

Are you still having periods?	☐ No ☐ Yes	Are they regular? ☐ No ☐ Yes
Have you had a hysterectomy?	☐ No ☐ Yes	Year: Why was this done?
Have you had your ovaries removed?	☐ No ☐ Yes	Year:

Age at menopause: Date of last menstrual period:

Do/did you use oral contraceptives? ☐ No ☐ Yes How long?	Do/did you use injectable contraceptives? ☐ No ☐ Yes What drug?

Do/did you take hormone replacement therapy? ☐ No ☐ Yes What drug? How long?

Have you ever used fertility drugs? ☐ No ☐ Yes How long?

Number of pregnancies: Number of live births: Age at first full term pregnancy:

Did you breastfeed: ☐ No ☐ Yes

Could you be pregnant now?	☐ No ☐ Yes	
Do you have regular mammograms?	☐ No ☐ Yes	Last exam: / /
Do you have regular PAP tests?	☐ No ☐ Yes	Last exam: / /
Do you have regular breast exams by a doctor?	☐ No ☐ Yes	Last exam: / /
Do you do regular breast self-exams?	☐ No ☐ Yes	Last exam: / /

ADVANCE DIRECTIVE

Do you have either type of these Advance Directives? ☐ Living will ☐ Durable power of attorney ☐ Neither

Date of directive: / /

Would you like for us to give you information on Advance Directives? ☐ No ☐ Yes

ABUSE ASSESSMENT

Are you in a harmful physical or emotional relationship? ☐ No ☐ Yes

If yes: ☐ hit/kicked ☐ threatened ☐ forced to have sex ☐ have you been denied food, water, medicine

Other: _____

Do you have a safe place to go when you leave today? ☐ No ☐ Yes

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FUNCTIONAL – Have you had any of the following problems recently?

Difficulty with strenuous activities you were able to do before? ☐ No ☐ Yes	
Trouble walking? ☐ No ☐ Yes	Falling? ☐ No ☐ Yes
Which of these activities can you do for yourself? ☐ cook ☐ clean ☐ bathe ☐ shop ☐ drive ☐ dress	
Confined to bed or chair ☐ less than 50% of day ☐ greater than 50% of day ☐ not confined	
Trouble understanding what is said to you? ☐ No ☐ Yes	Trouble speaking? ☐ No ☐ Yes
Able to carry on daily activities as normal ☐ No ☐ Yes	

PHARMACY INFORMATION

Name of Pharmacy:	Phone number of Pharmacy:

ALLERGIES (include medicines, latex, food, other) ☐ No known Allergies

ALLERGY TO:	DESCRIBE THE REACTION:

MEDICATIONS – List all prescription and over the counter medications, as well as herbs and supplements.

MEDICATION NAME ☐ I do not take any Medications	DOSE	HOW OFTEN	ROUTE: Taken by mouth, injection, put on skin, other (please describe)

PHYSICIANS: Please list all of your doctors

NAME OF DOCTOR	SPECIALTY	TELEPHONE #/FAX #	ADDRESS

NAME OF DENTIST		TELEPHONE #/FAX #	ADDRESS

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