

NAME: _____

D.O.B.: _____

**NEW PATIENT QUESTIONNAIRE
- PLEASE COMPLETE ALL PAGES -**

PATIENT IDENTIFICATION

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.

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



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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.

<p>GENERAL</p> <input type="checkbox"/> Chills <input type="checkbox"/> Night sweats <input type="checkbox"/> Fever <input type="checkbox"/> Tiredness <input type="checkbox"/> Weakness <input type="checkbox"/> Lack of appetite <input type="checkbox"/> Weight gain <input type="checkbox"/> Weight loss <p>GENITOURINARY</p> <input type="checkbox"/> Excessive urination <input type="checkbox"/> Difficulty in starting stream <input type="checkbox"/> Urinary dribbling/incontinence <input type="checkbox"/> Kidney/Bladder Infections <input type="checkbox"/> Blood in urine <input type="checkbox"/> Night time urination <input type="checkbox"/> Pain or burning with urination <input type="checkbox"/> Urgency in urination <p>MEN ONLY</p> <input type="checkbox"/> Erection difficulties <input type="checkbox"/> Impotence <input type="checkbox"/> Lump in testicles <input type="checkbox"/> Penis discharge <input type="checkbox"/> Sore on penis <p>WOMEN ONLY</p> <input type="checkbox"/> Vaginal discharge/itching <input type="checkbox"/> Painful intercourse <input type="checkbox"/> Bleeding between periods <input type="checkbox"/> Extreme menstrual pain <input type="checkbox"/> Abnormal Pap smear <input type="checkbox"/> Hot flashes/night sweats <input type="checkbox"/> Breast lump <input type="checkbox"/> Nipple discharge <input type="checkbox"/> Breast pain	<p>SKIN</p> <input type="checkbox"/> Bruising <input type="checkbox"/> Changes in moles <input type="checkbox"/> Changes in hair texture <input type="checkbox"/> Changes in nail texture <input type="checkbox"/> Changes in skin color <input type="checkbox"/> Extreme dryness <input type="checkbox"/> Eczema <input type="checkbox"/> Hives <input type="checkbox"/> Lumps <input type="checkbox"/> Rashes <p>EYES, EARS, NOSE, THROAT</p> <input type="checkbox"/> Blurred vision <input type="checkbox"/> Crossed eyes <input type="checkbox"/> Decreased ability to see <input type="checkbox"/> Double vision <input type="checkbox"/> Eye pain <input type="checkbox"/> Earache <input type="checkbox"/> Ear drainage <input type="checkbox"/> Ringing in ears <input type="checkbox"/> Nosebleeds <input type="checkbox"/> Runny nose <input type="checkbox"/> Stuffy nose <input type="checkbox"/> Post-nasal drip <input type="checkbox"/> Sinus problems <input type="checkbox"/> Sneezing <input type="checkbox"/> Hay fever <input type="checkbox"/> Hoarseness <input type="checkbox"/> Sore throat <input type="checkbox"/> Difficulty swallowing <input type="checkbox"/> Pain with swallowing <input type="checkbox"/> Dentures <input type="checkbox"/> Dental problems	<p>ENDOCRINE</p> <input type="checkbox"/> Excessive hunger <input type="checkbox"/> Excessive thirst <input type="checkbox"/> Excessive urination <input type="checkbox"/> Heat intolerance <input type="checkbox"/> Cold intolerance <input type="checkbox"/> Thyroid problem <input type="checkbox"/> High sugar <input type="checkbox"/> Low sugar <input type="checkbox"/> Diabetes <p>MUSCULOSKELETAL</p> <input type="checkbox"/> Back pain <input type="checkbox"/> Joint aches <input type="checkbox"/> Joint stiffness/swelling <input type="checkbox"/> Redness of any joint <input type="checkbox"/> Muscle aches <input type="checkbox"/> Pain down back of legs <input type="checkbox"/> Weakness <p>GASTROINTESTINAL</p> <input type="checkbox"/> Loss of appetite <input type="checkbox"/> Indigestion <input type="checkbox"/> Stomach pain <input type="checkbox"/> Nausea/vomiting <input type="checkbox"/> Vomiting blood <input type="checkbox"/> Bloating <input type="checkbox"/> Constipation <input type="checkbox"/> Hemorrhoids <input type="checkbox"/> Black stools <input type="checkbox"/> Change in stool color <input type="checkbox"/> Change in bowel habits <input type="checkbox"/> Rectal bleeding <input type="checkbox"/> Diarrhea <input type="checkbox"/> Laxative use <input type="checkbox"/> Excessive belching	<p>CARDIOVASCULAR</p> <input type="checkbox"/> Heart palpitations <input type="checkbox"/> Irregular heart beat <input type="checkbox"/> Chest pain at rest <input type="checkbox"/> Chest pain with exertion <input type="checkbox"/> Wake up at night short of breath <input type="checkbox"/> Sleep with 2 or more pillows <input type="checkbox"/> High blood pressure <input type="checkbox"/> Low blood pressure <input type="checkbox"/> Poor circulation <input type="checkbox"/> Swelling of ankles/legs <input type="checkbox"/> Varicose veins <p>PSYCHIATRIC</p> <input type="checkbox"/> Anxiety <input type="checkbox"/> Depression <input type="checkbox"/> Difficulty in going to sleep <input type="checkbox"/> Loss of sleep <input type="checkbox"/> Early morning awakening <input type="checkbox"/> Difficulty with memory <input type="checkbox"/> Difficulty with thinking or problem solving.	<p>NEUROLOGIC</p> <input type="checkbox"/> Headache <input type="checkbox"/> Dizziness <input type="checkbox"/> Fainting <input type="checkbox"/> Blackouts <input type="checkbox"/> Difficulty in speaking <input type="checkbox"/> Loss of balance <input type="checkbox"/> Loss of coordination <input type="checkbox"/> Loss of sensation <input type="checkbox"/> Numbness <input type="checkbox"/> Paralysis or weakness of limbs <input type="checkbox"/> Seizures <p>RESPIRATORY</p> <input type="checkbox"/> Asthma <input type="checkbox"/> Wheezing <input type="checkbox"/> Bronchitis <input type="checkbox"/> Pneumonia <input type="checkbox"/> Dry cough <input type="checkbox"/> Cough up phlegm <input type="checkbox"/> Cough up blood <input type="checkbox"/> Pain in chest when you cough, sneeze or move <input type="checkbox"/> Shortness of breath at rest <input type="checkbox"/> Shortness of breath with exertion
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DO NOT WRITE BELOW THIS LINE



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STAYING HEALTHY

Have you had a flu shot?	<input type="checkbox"/> No <input type="checkbox"/> Yes	When:
Have you had a pneumonia shot?	<input type="checkbox"/> No <input type="checkbox"/> Yes	When:
Have you had a sigmoidoscopy/colonoscopy?	<input type="checkbox"/> No <input type="checkbox"/> Yes	When:
Do you exercise on a regular basis?	<input type="checkbox"/> No <input type="checkbox"/> Yes	How often:
Do you wear glasses?	<input type="checkbox"/> No <input type="checkbox"/> Yes	Date of last eye doctor visit?

MALE HISTORY N/A

Do you have regular prostate exams?	<input type="checkbox"/> No <input type="checkbox"/> Yes	When:
Do you have regular PSA tests?	<input type="checkbox"/> No <input type="checkbox"/> Yes	When:
Do you do regular testicular exams on yourself?	<input type="checkbox"/> No <input type="checkbox"/> Yes	When:

FEMALE HISTORY N/A Age that you started having periods:

Are you still having periods?	<input type="checkbox"/> No <input type="checkbox"/> Yes	Are they regular?	<input type="checkbox"/> No <input type="checkbox"/> Yes
Have you had a hysterectomy?	<input type="checkbox"/> No <input type="checkbox"/> Yes	Year:	Why was this done?
Have you had your ovaries removed?	<input type="checkbox"/> No <input type="checkbox"/> Yes	Year:	
Age at menopause:	Date of last menstrual period:		
Do/did you use oral contraceptives? How long?	<input type="checkbox"/> No <input type="checkbox"/> Yes	Do/did you use injectable contraceptives? What drug?	<input type="checkbox"/> No <input type="checkbox"/> Yes
Do/did you take hormone replacement therapy?	<input type="checkbox"/> No <input type="checkbox"/> Yes	What drug?	How long?
Have you ever used fertility drugs?	<input type="checkbox"/> No <input type="checkbox"/> Yes	How long?	
Number of pregnancies:	Number of live births:	Age at first full term pregnancy:	
Did you breastfeed:	<input type="checkbox"/> No <input type="checkbox"/> Yes		
Could you be pregnant now?	<input type="checkbox"/> No <input type="checkbox"/> Yes		
Do you have regular mammograms?	<input type="checkbox"/> No <input type="checkbox"/> Yes	Last exam:	
Do you have regular PAP tests?	<input type="checkbox"/> No <input type="checkbox"/> Yes	Last exam:	
Do you have regular breast exams by a doctor?	<input type="checkbox"/> No <input type="checkbox"/> Yes	Last exam:	
Do you do regular breast self-exams?	<input type="checkbox"/> No <input type="checkbox"/> Yes	Last exam:	

ADVANCE DIRECTIVE

Do you have either type of these Advance Directives?	<input type="checkbox"/> Living will <input type="checkbox"/> Durable power of attorney <input type="checkbox"/> Neither
Date of directive:	/ /
Would you like for us to give you information on Advance Directives?	<input type="checkbox"/> No <input type="checkbox"/> 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



