**New Patient Questionnaire**

**NAME:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Referring Physician Name & Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Care Physician Name & Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**REASON FOR THE VISIT:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MEDICAL HISTORY (Year and Diagnosis)** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**OPERATIONS (Year and Procedure)**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**FAMILY HISTORY:** Have any of your immediate family had any of the following:

Write the appropriate family member beside the condition (parent, children, brother, sister, uncle, aunt, grandparent)

|  |  |  |
| --- | --- | --- |
| Colon Cancer \_\_\_\_\_\_\_ | Thyroid Disease \_\_\_\_\_\_\_ | Rheumatoid Arthritis \_\_\_\_\_\_\_ |
| Crohn’s Disease \_\_\_\_\_\_\_ | Kidney Disease \_\_\_\_\_\_\_ | High Blood Pressure \_\_\_\_\_\_\_ |
| Ulcerative Colitis \_\_\_\_\_\_\_ | Heart Disease \_\_\_\_\_\_\_ | Auto-Immune Disorders\_\_\_\_\_\_ |
| Liver Disease \_\_\_\_\_\_\_Celiac Disease \_\_\_\_\_\_\_  | Lung Disease \_\_\_\_\_\_\_Diabetes \_\_\_\_\_\_\_ | Other Cancer \_\_\_\_\_\_\_Osteoporosis \_\_\_\_\_\_\_ |

**SOCIAL HISTORY:**

Marital Status \_\_\_\_\_\_\_\_\_\_ Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Number of Children \_\_\_\_\_\_\_\_\_\_ Do you have a Caregiver? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you smoke cigarettes or have you ever smoked cigarettes?

( ) Yes ( ) No

If yes, how many packs per day \_\_\_\_\_ how many years \_\_\_\_\_ If you quit, when did you quit \_\_\_\_\_\_\_\_

Do you drink alcohol?

( ) Yes ( ) No

If yes, how many drinks per day/week/month \_\_\_\_\_ how many years \_\_\_\_\_

Have you ever had a problem with alcohol or drugs?

( ) Yes ( ) No

If you are on TPN or TF: Name / phone of Home Infusion \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home Nursing\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **NAME:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**DRUG ALLERGIES or SENSITIVITY with associated reaction:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Current Medications** – List the name, dose, and frequency of all medications, including over the counter drugs. Put a check on the line under Route if drug is NOT taken by mouth. In the Dose column give total amount per dose or dose of pill and number of pills. For example 50 mg or 25 mg – two tablets.

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Name of Drug** |  | **Dose****Such as mg, units, cc** |  | **Frequency How many times a day** |  | **Route** |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |

**REVIEW OF SYSTEMS NAME \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

|  |  |
| --- | --- |
| **Check “YES” if you have any of the following problems** **General YES**  Activity change **( )** Appetite change **( )** Chills **( )** Fatigue **( )** Fever  **( )** Unexpected weight change **( )** **HEENT YES** Dental problem **( )** Facial swelling **( )** Mouth sores **( )** Visual Disturbance **( )****Respiratory YES** Cough **( )** **Gastrointestinal YES** Abdominal swelling **( )**Abdominal pain **( )** Constipation **( )**Diarrhea **( )**Nausea and/or vomiting **( )**Difficulty swallowing **( )** Heartburn **( )** Increase in stool output **( )** Bloody or dark stools **( )** Incontinence of stool **( )** | **Bladder YES** Change in frequency of urination **( )** Decreased urination **( )** **Muscles / Extremities YES** Joint pain **( )** Muscle pain or weakness **( )** Gait problem **( )** Leg swelling **( )** **Skin YES** Pallor **( )**Rash **( )** Skin Ulcers/Wound **( )** Easy bruising/bleeding **( )** **Neurological YES** Dizziness **( )** Light-headedness **( )** Speak difficulty **( )** Fainting **( )**Weakness **( )** **Mood / Sleep YES** Confusion **( )** Nervous/Anxious **( )**Depression **( )** **Allergy YES** Food allergies **( ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |