General Internal Medicine and Medicine-Pediatrics clinic

New Patient Questionnaire

Patient Name: _______________________________Date of Birth:________________Today's Date: ________________

What is the purpose of today's visit?

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Please list your current **medications** and dosages, including over-the-counter medications.

List any **allergies** to medications, food, or environmental factors.

Do you live with anybody?
If so, whom?

Are you employed?
If so, what is your occupation?

Do you exercise regularly?
- o No
- o Yes
  What exercise and how often?____________________
  ____

Do you smoke tobacco?
- o Never smoker
- o Current smoker
  ___ packs per ______ for ___ years
- o Former smoker
  ___ packs per ______ for ___ years
  When did you quit? ___________

Do you ever drink beer, wine, or liquor?
- o No
- o Yes
  Men: Do you ever drink more than 4 drinks per day or 14 drinks per week?
  ____
  Women: Do you ever drink more than 3 drinks per day or 7 drinks per week?
  ____

Have you ever used recreational drugs or prescription drugs for non-medical reasons?
- o No
- o Yes
  Which drug(s)?________________

Are you sexually active?
- o No
- o Yes – with women
- o Yes – with men
- o Yes – with both women and men

Please check any of the following items regarding your current or past **medical problems**:

- o No significant medical history
- o Alcoholism
- o Anemia
- o Anxiety
- o Asthma
- o Birth defects
- o Bleeding disorder or blood clots
- o Cancer
- o Depression or bipolar disorder
- o Diabetes
- o Eating disorder
- o Heartburn / reflux / GERD
- o Heart disease / angina
- o Kidney disease
- o High blood pressure
- o High cholesterol
- o Liver disease
- o Lung / respiratory disease
- o Osteoporosis or fractures
- o Schizophrenia
- o Seizure
- o Sickle cell disease
- o Stroke or TIA (mini stroke)
- o Suicide attempt

Any other medical problems not listed above? ____

____

Have you had any **surgeries** in the past, and if so, when?

please turn over – more on back

Please list your **family history** (medical problems pertaining to your family members). Include any relatives with high blood pressure, diabetes, heart disease, cancer, and mental illness. Indicate relation and age of onset.
For example, "breast cancer – mother, age 66."

Please check any **symptoms *currently or recently* experienced** within the past month:

GENERAL
- fever
- chills
- abnormal weight gain
- abnormal weight loss
- fatigue

EYES
- decreased vision
- double vision
- eye pain

EARS / NOSE / THROAT
- decreased hearing
- difficulty swallowing
- dizziness
- hoarseness
- sinus congestion
- sore throat
- runny nose
- ear ache

HEART / CIRCULATION
- chest pain
- fainting
- pain in legs with exertion
- palpitations
- shortness of breath at night
- shortness of breath when lying down
- shortness of breath with exertion
- swelling of hands or feet

LUNGS
- chest pain
- shortness of breath
- cough
- wheezing

GASTROINTESTINAL
- abdominal pain
- blood in stools
- change in bowel habits
- constipation
- diarrhea
- frequent indigestion
- nausea
- vomiting
- vomiting blood
- heartburn
- difficulty swallowing

GENITOURINARY
- abnormal vaginal discharge
- decreased urination
- burning with urination
- blood in urine
- loss of bladder control
- urination at night
- frequent urination
- heavy periods
- severe menstrual cramps

MUSCULOSKELETAL
- back pain
- neck pain
- joint pain
- joint swelling
- muscle pain
- muscle weakness

SKIN
- rash
- change in moles
- suspicious spots on skin

NEUROLOGIC
- dizziness
- fainting
- headaches
- numbness
- weakness
- seizures
- tremors

MENTAL HEALTH
- anxiety
- depression
- thoughts of suicide
- eating disorder

METABOLISM
- feeling colder than people around you
- excessive urination
- excessive thirst
- feeling warmer than people around you
- weight change

HEMATOLOGY
- abnormal bruising
- abnormal bleeding
- enlarged lymph nodes

ALLERGY
- bee sting allergy
- food allergies
- hives
- persistent infections

BREAST
- left breast lump
- right breast lump
- nipple discharge
- bloody nipple discharge
- breast pain
- abnormal mammogram
- breast enlargement

Please give completed form to your medical provider at the beginning of your visit