NEW PATIENT QUESTIONNAIRE

I. PATIENT INFORMATION

Today's Date: _____ Patient MR#: _____

Name: _____
Last First MI (Jr, Sr. etc.)

Date of Birth: _____

Family Physician: _____

Referred By: _____

Appointment Date: _____

II. CHIEF COMPLAINT THAT BRINGS YOU HERE TODAY

_____

III. CURRENT MEDICATION (INCLUDE OVER-THE-COUNTER AND HERBAL SUPPLEMENTS)

❑ 30 day supply or ❑ 90 day supply

Drug / Dose / Frequency	Drug / Dose / Frequency
1. _____	11. _____
2. _____	12. _____
3. _____	13. _____
4. _____	14. _____
5. _____	15. _____
6. _____	16. _____
7. _____	17. _____
8. _____	18. _____
9. _____	19. _____
10. _____	20. _____

IV. MEDICATION ALLERGIES

(Food / X-ray dye / Seafood/ Other) _____

V. PAST MEDICAL HISTORY: (circle all that apply)

Heart Attack	Diabetes	COPD	Hyperthyroidism	GERD
Hypertension	Stroke	Rheumatic Fever	Hypothyroidism	PUD
Hypercholesterolemia	TIA	PVD	Renal failure	Arthritis
CHF	Arrhythmia	PVCs	back problems	Anxiety
Cardiomyopathy	Atrial fibrillation	V Tach	Sciatica	Depression
Enlarged heart	Atrial flutter	Cancer	Chemo/Radiation	Alzheimer's

Other: _____

VI. PAST SURGICAL HISTORY: (circle all that apply)

Balloon	Congenital Heart	back surgery	Colostomy
Coronary stent	MVR	Cholecystectomy	TKR/THR
CABG	MV repair	Appendectomy	TAH/BSO
Pacemaker	AVR	Tonsils	Thyroidectomy
ICD	ASD repair	Hernia repair	Pneumonectomy
RFA	VSD repair	TURP/Prostatectomy	Colon resection
Carotid endarterectomy	PV surgery	Amputation	Fracture
Ablation	Cardioversion	Vascular leg surgery	

Other: _____

VII. CARDIAC RISK FACTORS: (check all that apply)

- ☐ Cigarette smoker
- ☐ Ex- smoker
- ☐ High Blood Pressure
- ☐ High cholesterol/ triglycerides
- ☐ Diabetes
- ☐ Over-weight
- ☐ Family history of heart disease

VIII. Personal & Family History:

Occupation _____ Retired _____
Smoker _____ pack/day
Alcohol _____number/day/week
Caffeine _____ cups/day
Exercise _____ never _____rare _____ occasional _____regular _____

	Living - health problems	Age deceased & cause
Father		
Mother		
Siblings		

Health Care Consumer Questionnaire

Patient Name _____ DOB ____/____/_____ Date ____/____/_____

Review of Systems In the last 6 months, have you experienced any of the following symptoms? Respond to each.

Constitutional

Weight Loss or Gain	☐Yes ☐No
Appetite changes (increased or decreased)	☐Yes ☐No
Fatigue, profound and impairs daily function	☐Yes ☐No
Fever	☐Yes ☐No
Shakes/sweats from lack of alcohol or drug	☐Yes ☐No

Eyes

Eye pain or drainage	☐Yes ☐No
Visual changes	☐Yes ☐No
Dry, irritated eyes	☐Yes ☐No

ENT/Mouth

Ear pain or drainage	☐Yes ☐No
Frequent sinus infections	☐Yes ☐No
Hearing changes or loss	☐Yes ☐No
Nosebleeds	☐Yes ☐No
Dizziness	☐Yes ☐No

Respiratory

Blood in your sputum	☐Yes ☐No
Chest tightness	☐Yes ☐No
Cough lasting >1 month, productive or not	☐Yes ☐No
Shortness of breath	☐Yes ☐No
Wheezing	☐Yes ☐No
Chest pain with inhalation or coughing	☐Yes ☐No

Cardiovascular

Chest pain or heaviness	☐Yes ☐No
Palpitations	☐Yes ☐No
Fainting or near fainting spells	☐Yes ☐No
Swelling of feet or legs	☐Yes ☐No
Shortness of breath lying flat in bed	☐Yes ☐No

GastroIntestinal

Abdominal pain	☐Yes ☐No
Blood in your stool	☐Yes ☐No
Constipation	☐Yes ☐No
Diarrhea or Food Intolerance	☐Yes ☐No
Heartburn or Indigestion	☐Yes ☐No
Vomiting or nausea lasting for >1 day	☐Yes ☐No
Swallowing difficulty	☐Yes ☐No

Psych

Anxiety without clear explanation	☐Yes ☐No
Sadness lasting for days or weeks	☐Yes ☐No
Hearing voices	☐Yes ☐No
Thoughts of hurting yourself	☐Yes ☐No
Thought of hurting others	☐Yes ☐No
Fear of people, places or things	☐Yes ☐No

Genitourinary

Blood in your urine	☐Yes ☐No
Menstrual changes	☐Yes ☐No
Urinating that is painful or difficult	☐Yes ☐No
Erection problems	☐Yes ☐No
Vaginal discharge or bleeding	☐Yes ☐No

Musculoskeletal

Broken bones	☐Yes ☐No
Joint pain or swelling	☐Yes ☐No
Muscle aches	☐Yes ☐No
Muscle weakness	☐Yes ☐No
Back pain	☐Yes ☐No

Skin/Breasts

Masses or lumps	☐Yes ☐No
Nipple discharge	☐Yes ☐No
Rashes or nonhealing ulcers	☐Yes ☐No

Neurologic

Seizures	☐Yes ☐No
Coughing or choking with swallowing	☐Yes ☐No
Excessive daytime sleepiness	☐Yes ☐No
Extremity pain or burning sensations	☐Yes ☐No
Hallucinations	☐Yes ☐No
Numbness or tingling	☐Yes ☐No
Difficulty falling asleep, staying asleep	☐Yes ☐No

Endocrinologic

Hair loss	☐Yes ☐No
Frequent urination	☐Yes ☐No
Increased thirst	☐Yes ☐No
Heat or cold intolerance	☐Yes ☐No

Heme/Lymph

Bleeding from gums or nose	☐Yes ☐No
Unexplained bruising	☐Yes ☐No
Night Sweats	☐Yes ☐No
Swollen, painful lymph nodes	☐Yes ☐No

Allergy/Immun

Watery eyes	☐Yes ☐No
Runny nose	☐Yes ☐No
Food intolerance	☐Yes ☐No
Frequent skin sores	☐Yes ☐No