New Patient Medical Questionnaire

Name:_____
Current Family Physician or internist, if any: _____

MEDICATIONS - Please list current medications and dose:

Medication Name	Dose	How many	How often	Medication Name	Dose	How many	How often

DO YOU HAVE ANY ALLERGIES? _____
If yes, please list all:_____

PREVIOUS SURGERIES – Please list all below:

Year	Surgery	Year	Surgery

HOSPITAL ADMISSIONS – Please list previous hospitalizations EXCEPT Surgery below:

Year	Hospitalized for:	Year	Hospitalized for:

SOCIAL HISTORY

Current Employment Status:
____ Currently working full time
____ Currently working part time
____ On leave of absence
____ Unemployed
____ Student
____ Retired (not due to health)
____ Disabled (due to health)

Occupation:_____

Marital Status: _____
Number of Children: _____
Current Living Arrangements:
____ I live alone
____ I live with my spouse or significant other
____ I live in a residential health care facility
____ Other: _____

- Do you ever drink alcohol? _____How much do you drink? _____
- Do you currently smoke? _____ What do you smoke? _____
  If you smoke, how many years have you smoked? _____
  If you quit smoking, when? _____
- Do you have a history of substance abuse? _____

FAMILY HISTORY

List any medical problems family members have had:

_____
_____
_____

CONTINUED ON BACK

REVIEW OF SYSTEMS OF PATIENT

Symptoms: Check symptoms you currently have or have had in the past.

ENDOCRINE

- ❑ Diabetes

If yes, how many years:____

- ❑ Low blood sugar
- ❑ Thyroid problems

CARDIOVASCULAR

- ❑ Rheumatic fever
- ❑ Heart murmur
- ❑ Chest pain
- ❑ Heart attack
- ❑ Irregular heartbeat
- ❑ EKG changes
- ❑ Angina
- ❑ Ankle swelling
- ❑ Valve replacement
- ❑ Congestive heart failure

NEUROLOGIC

- ❑ Stroke
- ❑ Seizures
- ❑ Neurological (loss of sensation)

Mental health/phobias:

- ❑ Anxiety
- ❑ Depression
- ❑ Psychosis
- ❑ Confusion
- ❑ Memory loss
- ❑ Down's syndrome

EAR, NOSE, THROAT

- ❑ Difficulty opening mouth
- ❑ Sinus infections
- ❑ Balance problems

EYES

- ❑ Double vision
- ❑ Severe headaches
- ❑ Legally blind
- ❑ Macular degeneration
- ❑ Glaucoma

PULMONARY

Lung problems:

- ❑ Asthma
- ❑ Chronic cough
- ❑ Pneumonia
- ❑ Wheezing
- ❑ Shortness of breath
- ❑ Emphysema
- ❑ Abnormal chest x-ray
- ❑ Sleep apnea

GASTROINTESTINAL

- □ Liver problems (jaundice/hepatitis)

Stomach Problems:

- ❑ Ulcers
- ❑ Hiatal hernia
- ❑ Reflux
- ❑ Heartburn
- ❑ Bleeding

Bowel Problems:

- ❑ Irritable bowel
- ❑ Diverticulosis
- ❑ Obstruction
- ❑ Hemorrhoids

GENITOURINARY

- ❑ Nocturia
- ❑ Infections
- ❑ Frequency
- ❑ Pain/Burning

ORTHOPEDIC/MUSCLE

- ❑ Back problems (strain, disc problems, tingling of hands or feet, sciatica)
- ❑ Broken bones of neck or spine

Arthritis in other joints:

- ❑ Hands
- ❑ Wrists
- ❑ Shoulders
- ❑ Elbows
- ❑ Feet
- ❑ Ankles
- ❑ Hips
- ❑ Knees

- ❑ Muscle disorders (muscular dystrophy, myasthenia gravis)
- ❑ Fibromyalgia

GENERAL

- ❑ Phlebitis
- ❑ Pulmonary embolism
- ❑ Blood clots in legs
- ❑ High blood pressure
- ❑ Tuberculosis
- ❑ Skin Problems

(eczema, fragile skin, etc)

HEMATOLOGIC/IMMUNOLOGIC

- ❑ Hemophilia
- ❑ Transfusion problems
- ❑ Bleeding tendency

Specify if any cancer:

- ❑ Breast cancer
- ❑ Prostate cancer
- ❑ Colon cancer
- ❑ Lung cancer
- ❑ Skin cancer
- ❑ Uterine cancer

Have you been recently exposed to any communicable diseases? (chicken pox or measles)

____ Yes _____ No

Have you ever had a bad reaction to anesthesia?

____ Yes _____ No

Has any blood relative had a bad reaction to anesthesia?

____ Yes _____ No