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NEW PATIENT QUESTIONNAIRE/REVIEW OF SYSTEMS

To all of my patients,

The following questionnaire is intended to help me better evaluate and treat your medical problems. I appreciate you filling it out in its entirety. Should you have any questions about what information to include don't hesitate to ask the office staff. Thank you.

Name: _____

Date of Evaluation: _____ **Birth date:** _____ **Age:** _____

Telephone: () _____

Referral Source: _____

1. What is the medical problem you need addressed today? _____

2. When did you first notice the problem? _____

3. Did you have other problems at the same time this symptom started? _____

If yes, what were they? _____

4. How often do you have the problem? _____

5. How long does the problem last? _____

6. Does anything make your problem worse? _____

7. Does anything make your problem better? _____

8. Does this problem affect your sleep? _____

9. How does this affect your life? _____

10. Have you been evaluated for this problem before? _____
11. If so, by whom? _____
12. What was the diagnosis given? _____
13. Did you receive any treatment? _____
14. What was the treatment and how often did you receive it? _____

15. Is there anyone in your family with similar symptoms? _____

PAST MEDICAL HISTORY/ CURRENT ILLNESSES:

- | | | |
|--|---|--|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Asthma | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Bladder Disease | <input type="checkbox"/> Bleeding Tendencies | <input type="checkbox"/> Bronchitis |
| <input type="checkbox"/> Cancer: What Type? _____ | | <input type="checkbox"/> Cataracts |
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Dementia(memory problems) | <input type="checkbox"/> Diabetes Mellitus |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Gallbladder Disease | |
| <input type="checkbox"/> Gastro-Esophageal Reflux Disease | | |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Hearing loss | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> Hepatitis: <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C | | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Influenza | <input type="checkbox"/> Hyperlipidemia (high cholesterol or triglycerides) | |
| <input type="checkbox"/> Jaundice | <input type="checkbox"/> Kidney Failure | <input type="checkbox"/> Kidney Stones |
| <input type="checkbox"/> Measles | <input type="checkbox"/> Mental Illness | <input type="checkbox"/> Mumps |
| <input type="checkbox"/> Poliomyelitis | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Sexually Transmitted Disease | | |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Skin Lesions/rash | |
| <input type="checkbox"/> Sickle cell disease | <input type="checkbox"/> Stroke | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Tuberculosis | | |
| <input type="checkbox"/> Other: | | |

OPERATIONS/HOSPITALIZATIONS:

INJURIES/ACCIDENTS:

IMPLANTS (breast, eye, penile, etc.):

Please list all of your prescription medications and dosages: _____

Please list all over the counter medications and vitamins you take. If you take health supplements please list them as well.

LIST ALLERGIES OR REACTIONS TO MEDICATIONS:

FAMILY HISTORY: (check those that a family member has had)

Mother's age (or age at death) _____ Alive? Yes ___ No ___

Mother's Medical Problems: _____

Father's age (or age at death) _____ Alive? Yes ___ No ___

Father's Medical Problems: _____

___ Alzheimer's Disease

___ Asthma

___ Arthritis

___ Cancer

___ Cataracts

___ Diabetes

___ Epilepsy

___ Heart Problems

___ Hearing Loss

___ Kidney Disease

___ Thyroid Disease

___ High Blood Pressure

___ Other: _____

SOCIAL HISTORY:

Level of Education: High school _____ College _____ Graduate _____

Hobbies: _____

Job History: (Please list all occupations especially those where there is risk of exposure to toxic chemicals or gases): _____

Travel History: (Please list travel to foreign countries over the past 3 years): _____

HABITS:

	Present	Past	Amount
Tobacco(snuff, chewing, pipes, cigars)	___ Y/N	___ Y/N	_____
Alcohol	___ Y/N	___ Y/N	_____
Illicit Drugs	___ Y/N	___ Y/N	_____
Type of Drugs _____			
Exercise	___ Y/N	___ Y/N	_____

Marital Status: Single ___ Married ___ Divorced ___ Separated ___ Widowed ___

Please mark any of the following symptoms you have experienced in the past 6 months:

General: ___ Easily Fatigued
___ Fatigued upon waking up

___ Fatigued only after exercise
___ Excessive weight gain
(Specify: ___lbs. In ___weeks)

Allergies: ___Seasonal ___Medications other: _____

Blood: ___Anemia (Low Blood) ___Bleeding Disorders

Skin: Change in: ___Moles ___Moisture ___Texture (dry or oily)
Do you have: ___Bleeding ___Easily bruising ___Lesions
___Itching ___Scaling

Hair: ___Loss ___Excessive growth ___Change in texture or distribution

Glands: ___Enlargement ___Pain ___Drainage

Head: ___Trauma

Eyes: ___Color Blindness ___Infection ___Trauma
___Retinopathy ___Retinal detachment ___Visual Loss

Ear: ___Infection ___Loss or decrease of hearing
___Pain___Ringing in the ears

Nose: ___Frequent nasal/sinus infection ___Nose bleeds ___Runny nose

Mouth: ___Difficulty Chewing ___Excessive tongue movement ___Pain
___Infection ___Excessive salivation

Throat: ___Change in voice ___Frequent sore throat ___Hoarseness
___Pain or difficulty swallowing ___Trauma

Neck: ___Limitation of movement ___Pain___Stiffness
___Trauma ___Weakness

Breast: ___Lumps ___Nipple Discharge ___Change in size
___Skin lesions ___Change in skin color

Endocrine: ___Abnormal body growth or body configuration
___Excessive sweating/loss of sweating
___Increased thirst, urination, or hunger
___Infertility, or any hormonal abnormality
___Unusual sensitivity or in sensitivity to hot or cold

Cardiovascular: ___Angina ___Cold hand and /or feet
___Irregular heart rate or rhythm ___Pain in legs after walking
___Palpitations
___Shortness of breathe after exercise
___Shortness of breathe at night before falling asleep
___Shortness of breathe at night that awakens you
___Swelling of hands and/or feet

Respiratory: ___Asthma ___Coughing ___Night sweats
___Sputum production (coughing up mucus)
___Shortness of breath at rest
___Shortness of breathe after walking _____ blocks
___Other/lung infections

Gastrointestinal: ___Nausea ___Belching ___Vomiting
___Vomiting blood ___Abdomen pain ___Gas
___Change in bowel habits ___Change in bowel movements
___Jaundice (yellow skin) ___Blood in stool

- Genitourinary: Change in color of urine
 Decreased urination
 Painful urination
 Frequent urination at night
 Increased urination
 Change in menstrual cycle
 Erectile Dysfunction

- Skeletal: Scoliosis High arched feet

- Neurological: Loss of smell Double vision Loss of taste
 Dizziness Falls Balance difficulty
 Difficulty chewing Swallowing problems
 Excessive Eye movement Speech problems
 Decreased facial sensation
 Generalized weakness of muscles
 Sensation of heavy eyelids or difficulty holding eyelids open
 Muscle paralysis (inability to move any particular muscle)
Specify
 Decrease in muscle size (specify where: _____)
 Decrease in muscle strength (specify where: _____)
 Involuntary movement (uncontrollable shaking, twitching, spasm)
 Decreased or increased sense of touch
 Loss of sensation
 Burning pain Numbness Tingling
 Muscle pain, swelling, or tenderness (specify where _____)
 Easy muscle fatigability on exercise
 Muscle cramps
 Inability to control urine or bowels
 Excess sweating
 Impotence (inability to have or sustain an erection)
 Loss of early morning erections
 Memory Loss Difficulty concentrating Depression
 Mood swings
 Uncontrollable or inappropriate crying or laughing
 Sleep Disturbance
 Excessive sleeping (hyper somnolence)
 Inability to sleep (insomnia)
 Black outs Fainting spells Seizures Headaches
 Light headedness
 Low back pain
 with radiation to legs
 without radiation to legs
 Neck pain
 with radiation to arms
 without radiation to arms

Patient Signature

Date

Physician Signature

Date