Medical History- New Patient Questionnaire

1. Is there anyone in your family with heart disease, stroke, tuberculosis, diabetes, cancer (type), bleeding or clotting problems?

Please List any conditions and state how the person is related to you.

Condition: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Condition: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Condition: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Condition: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Condition: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Please list your usual occupation. Note whether your current occupation or any former occupation exposed you to dust, fumes, chemicals, pesticides, asbestos, radiation, blood or body fluids.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Note: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Do you have children? \_\_\_ Yes \_\_\_ NO Please give ages: \_\_\_\_, \_\_\_\_,\_\_\_\_\_
2. Are you parents alive? Mother \_\_\_ Yes \_\_\_\_ NO Father \_\_\_ Yes \_\_\_ NO

(Mother) If no, what was the cause of (Father) If no, what was the cause of

death?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ death?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Who was the referring PHYSICIAN? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If a friend or relative referred please give the name below. If you saw commercial, internet website, or billboard please state. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. List Full Name of any other Current Physicians. ( surgeon, primary care physician)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Specialty: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Specialty:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Specialty:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. (Women Only) List the date of your last OB/GYN exam and list the physician who you saw.

Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Physician\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. List medical conditions you have and for how long you’ve had the condition.

*Example: Condition: High blood pressure Date: December 1995*

Condition:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Condition:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Condition:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Condition:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Condition:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Have you stayed in the hospital overnight during the past year? \_\_\_ Yes \_\_\_\_ NO

How many times in the past year? \_\_\_\_\_\_\_\_\_ Which hospital? \_\_\_\_\_\_\_\_\_\_\_\_\_

List the reason and when you stayed overnight.

Reason:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_ Hospital: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reason:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_ Hospital: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reason:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_ Hospital: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Have you EVER had any surgery? \_\_\_ Yes \_\_\_ NO

List the type or reason for surgery including dates.

Reason:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_ Surgeon: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reason:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_ Surgeon: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reason:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_ Surgeon: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Have you had any previous treatments?

Radiation therapy? \_\_\_ Yes \_\_\_ NO What area? \_\_\_\_\_\_\_\_\_\_\_ Dates:\_\_\_\_\_\_\_\_\_\_\_\_

Chemotherapy? \_\_\_\_ Yes \_\_\_\_ NO What Drug?\_\_\_\_\_\_\_\_\_\_\_ Dates:\_\_\_\_\_\_\_\_\_\_\_\_

1. Do you have any previous MRI or PET scans? \_\_\_ Yes \_\_\_ NO

Where may we obtain a copy of these scans? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. List any allergies you have to food or medications: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Have you ever used tobacco in any form? \_\_\_ Yes \_\_\_ NO

Tobacco product: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Years? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you smoke **NOW**? \_\_\_ Yes \_\_\_ NO

Are you interested in quitting? \_\_\_ Yes \_\_\_ NO

1. Do you drink alcohol? \_\_\_ Yes \_\_\_ NO

How many drinks per month do you consume?

Beer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Wine: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Liquor: \_\_\_\_\_\_\_\_\_\_\_\_

1. Do you have a living will?

Do you have a durable power of attorney for medical care? \_\_\_ Yes \_\_\_ NO