New Patient Questionnaire

Last Name: First Name: MI:

Date of Birth: SSN:

Sex: Race: Marital Status:

Address:

City: State: Zip:

Email: Phone #:

Alt. Phone#:

Pharmacy:

Permission to Send Prescriptions Electronically? YES NO

Medications: Allergies:

Medical History: Surgical History:

#Years Smoked Cigarettes_____ #packs/Day (at the most) _____

Still Smoking? **Y** **N** Year Quit? _____

Type of Work? Diseases in the Family?

Exposure to Birds/Chickens/Silica/Coal Dust/ Asbestos?

Patient Signature_____ Date_____

REVIEW OF SYSTEMS: Please check if you have had any of the following:

GENERAL

- ☐ Weight Loss
- ☐ Fevers
- ☐ Chills
- ☐ Night sweats that drench sheets
- ☐ Fatigue/ Lethargy

HEENT

- ☐ Nosebleeds
- ☐ Seasonal Allergies
- ☐ Hayfever
- ☐ Tonsil/Adenoid Removal
- ☐ Hoarseness
- ☐ Swollen Tongue

NECK

- ☐ Thyroid Disease
- ☐ Goiter
- ☐ Swollen lymph glands

CARDIOVASCULAR

- ☐ Chest Pain
- ☐ Congestive Heart Failure
- ☐ Irregular Beats/ Palpitations
- ☐ Atrial Fibrillation
- ☐ Hypertension
- ☐ Heart Attack
- ☐ Fainting
- ☐ Waking up Gasping for Air
- ☐ Propping on Pillows to Breathe

GASTROINTESTINAL

- ☐ Heartburn/Reflux
- ☐ Difficulty swallowing
- ☐ Choking on food/drinks
- ☐ Stomach Ulcers
- ☐ Cirrhosis of Liver
- ☐ Hepatitis
- ☐ Rectal Bleeding
- ☐ Vomiting Blood

PULMONARY/CHEST

- ☐ Shortness of breath while walking
- ☐ Shortness of breath while showering/ getting dressed
- ☐ Shortness of breath while sitting still
- ☐ Coughing phlegm
- ☐ Coughing blood
- ☐ Pneumonia
- ☐ Blot clot in lungs
- ☐ Pulmonary Hypertension
- ☐ "Spot on the lung"
- ☐ Asthma
- ☐ Chronic Bronchitis
- ☐ Emphysema/ COPD
- ☐ Wheezing
- ☐ Lump in breast

INFECTIOUS DISEASES

- ☐ Exposure to TB
- ☐ Positive TB Skin Test
- ☐ HIV/ AIDS
- ☐ STD

MUSCULOSKELETAL

- ☐ Joint Swelling
- ☐ Joint Stiffness
- ☐ Lupus
- ☐ Rheumatoid Arthritis
- ☐ Psoriasis
- ☐ Back Pain
- ☐ Pain in Hands
- ☐ Swelling of the legs and feet

GENITOURINARY

- ☐ Blood in urine
- ☐ Bladder Infection
- ☐ Nephritis
- ☐ Kidney Stones
- ☐ Prostate Problems (Men Only)
- ☐ Miscarriage (Women Only

SLEEP

- ☐ Snoring
- ☐ Sleep Apnea
- ☐ CPAP/BIPAP
- ☐ Difficulty sleeping
- ☐ Daytime Sleepiness

HEME/ONCOLOGY

- ☐ Anemia (low blood)
- ☐ Easy Bruising/Bleeding
- ☐ Cancer
- ☐ Blood clots in legs/ lungs
- ☐ Cancer

NEUROLOGIC

- ☐ Headaches/ Migraines
- ☐ Stroke/ TIA
- ☐ Nerve Damage
- ☐ Memory Loss
- ☐ Convulsions, Seizures

HEALTH MAINTENANCE

Colonoscopy Date:

Pneumonia Shot Date:

Flu Shot Date:

(Women Only)

Mammogram Date:

PAP Date: