NEW PATIENT QUESTIONNAIRE
- PLEASE COMPLETE ALL PAGES -

Please check (✓) the box(es) (☐) that best describes the answer to each question below and fill in the blank(s) as needed.

Person Who Completed this Form: ☐ Self ☐ Other: Today's Date:

CONTACT INFORMATION
Email address:
Home phone number: Cell phone number:
Patient work number: May we call you at work? ☐ Yes ☐ No
May we leave information about your appointment with your family? ☐ Yes ☐ No
On answering machine? ☐ Yes ☐ No
If we cannot reach you, whom should we call?
How are you related? Phone #:
Why are you being seen today? Doctor who sent you here:

PAST MEDICAL CONDITIONS - Please check all that apply or have applied in the past.
☐ Atrial Fibrillation ☐ Cancer ☐ Herpes ☐ Pneumonia
☐ Alcoholism ☐ Congestive Heart Failure ☐ High blood pressure ☐ Prostate problem
☐ Anemia ☐ Diabetes ☐ type I ☐ type II ☐ High cholesterol ☐ Psychiatric problem
☐ Anxiety ☐ Depression ☐ HIV positive ☐ Stroke
☐ Arthritis/Gout ☐ Emphysema ☐ Kidney problems ☐ Thyroid problem
☐ Asthma ☐ Epilepsy ☐ Liver problems ☐ Tuberculosis
☐ Bleeding disorders ☐ Heart attack ☐ Mononucleosis ☐ Ulcers
☐ Bronchitis ☐ Hepatitis ☐ Osteoporosis ☐ Other:

DATE OF SURGERY TYPE OF SURGERY DOCTOR HOSPITAL WHERE PERFORMED

Have you ever had any type of blood transfusion? ☐ Yes ☐ No
Have you had radiation treatment before for any reason? ☐ Yes ☐ No When? Where?

SOCIAL HISTORY
What type of work did/do you do? ☐ Retired
Marital Status: ☐ single ☐ married ☐ divorced ☐ widowed ☐ life partner
Number of Children:
Do you live at home? ☐ Yes ☐ No ☐ alone ☐ assisted living ☐ nursing home
How far do you live from this clinic? How will you travel to the hospital/clinic?
Have you ever smoked? ☐ Yes ☐ No If yes, # packs per day for # years. Date Quit?
Do you drink alcohol? ☐ Yes ☐ No If yes, ☐ beer ☐ wine ☐ spirits
Number of drinks/week: If you used to drink, when did you stop? / /
Do you use drugs to get high? ☐ Yes ☐ No If yes, which drugs?

EDUCATIONAL ASSESSMENT
Preferred Language: Highest grade level completed: Degree:
Do you need an interpreter? ☐ Yes ☐ No

DO NOT WRITE BELOW THIS LINE
# NEW PATIENT QUESTIONNAIRE

**FAMILY HISTORY** – Please list all family members alive and deceased.

<table>
<thead>
<tr>
<th>RELATION</th>
<th>AGE</th>
<th>CANCER HISTORY</th>
<th>Age at Diagnosis</th>
<th>IF DECEASED, AGE &amp; CAUSE OF DEATH</th>
</tr>
</thead>
<tbody>
<tr>
<td>Father</td>
<td></td>
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<tr>
<td>Mother</td>
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<tr>
<td>Brother(s) #</td>
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<tr>
<td>Sister(s) #</td>
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</tr>
<tr>
<td>Children</td>
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</tr>
<tr>
<td>Grandmother on your Mother's side</td>
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<tr>
<td>Grandfather on your Mother's side</td>
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<tr>
<td>Grandfather on your Father's side</td>
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</tr>
<tr>
<td>Grandfather on your Father's side</td>
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</tr>
</tbody>
</table>

**SYMPTOMS** – Check symptoms you currently have.

- **GENERAL**
  - Chills
  - Fever
  - Night sweats
  - Tiredness
  - Weakness
  - Lack of appetite
  - Weight gain
  - Weight loss

- **GENITOURINARY**
  - Excessive urination
  - Difficulty in starting stream
  - Urinary dribbling/incontinence
  - Kidney/gladder infections
  - Blood in urine
  - Night time urination
  - Pain or burning with urination
  - Urgency in urination

- **MEN ONLY**
  - Erection difficulties
  - Impotence
  - Lump in testicles
  - Penis discharge
  - Sore on penis

- **WOMEN ONLY**
  - Vaginal discharge/itching
  - Painful intercourse
  - Bleeding between periods
  - Extreme menstrual pain
  - Abnormal Pap smear
  - Hot flashes/hot sweats
  - Breast lump
  - Nipple discharge
  - Breast pain

- **SKIN**
  - Bruising
  - Changes in moles
  - Changes in hair texture
  - Changes in nail texture
  - Changes in skin color
  - Extreme dryness
  - Eczema
  - Hives
  - Lumps
  - Rashes

- **EYES, EARS, NOSE, THROAT**
  - Blurred vision
  - Crossed eyes
  - Decreased ability to see
  - Double vision
  - Eye pain
  - Earache
  - Ear drainage
  - Ringing in ears
  - Nosebleeds
  - Runny nose
  - Stuffy nose
  - Post-nasal drip
  - Sinus problems
  - Sneezing
  - Hay fever
  - Hoarseness
  - Sore throat
  - Difficulty swallowing
  - Pain with swallowing
  - Dentures
  - Dental problems

- **ENDOCRINE**
  - Excessive appetite
  - Excessive thirst
  - Excessive urination
  - Heat intolerance
  - Cold intolerance
  - Thyroid problem
  - High blood pressure
  - Low blood pressure
  - Diabetes

- **MUSCULOSKELETAL**
  - Back pain
  - Joint aches
  - Joint stiffness/swelling
  - Redness of any joint
  - Muscle aches
  - Pain down back of legs
  - Weakness

- **GASTROINTESTINAL**
  - Loss of appetite
  - Indigestion
  - Stomach pain
  - Nausea/vomiting
  - Vomiting blood
  - Diarrhea
  - Constipation
  - Hemorrhoids
  - Black stools
  - Change in stool color
  - Change in bowel habits
  - Rectal bleeding
  - Diverticulitis
  - Intestinal blockage

- **CARDIOVASCULAR**
  - Heart palpitations
  - Irregular heart beat
  - Chest pain at rest
  - Chest pain with exertion
  - Wake up at night short of breath
  - Sleep with 2 or more pillows
  - High blood pressure
  - Low blood pressure
  - Poor circulation
  - Swelling of ankles/legs
  - Varicose veins

- **PSYCHIATRIC**
  - Anxiety
  - Depression
  - Difficulty in going to sleep
  - Loss of sleep
  - Early morning awakening
  - Difficulty with memory
  - Difficulty with thinking or problem solving

- **NEUROLOGIC**
  - Headache
  - Dizziness
  - Fainting
  - Blackouts
  - Difficulty in speaking
  - Loss of balance
  - Loss of coordination
  - Loss of sensation
  - Numbness
  - Paralysis or weakness of limbs
  - Seizures

- **RESPIRATORY**
  - Asthma
  - Wheezing
  - Bronchitis
  - Pneumonia
  - Dry cough
  - Cough up phlegm
  - Cough up blood
  - Pain in chest when you cough, sneeze or move
  - Shortness of breath at rest
  - Shortness of breath with exertion

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**NAME:**

**D.O.B.:**
**NEW PATIENT QUESTIONNAIRE**
- **PLEASE COMPLETE ALL PAGES**

### STAYING HEALTHY

<table>
<thead>
<tr>
<th>Question</th>
<th>No</th>
<th>Yes</th>
<th>When:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Have you had a flu shot?</td>
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<tr>
<td>Have you had a pneumonia shot?</td>
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<tr>
<td>Have you had a sigmoidoscopy/colonoscopy?</td>
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<tr>
<td>Do you exercise on a regular basis?</td>
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<tr>
<td>Do you wear glasses?</td>
<td></td>
<td></td>
<td>Date of last eye doctor visit?</td>
<td></td>
</tr>
</tbody>
</table>

### MALE HISTORY  □ N/A

<table>
<thead>
<tr>
<th>Question</th>
<th>No</th>
<th>Yes</th>
<th>When:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Do you have regular prostate exams?</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Do you have regular PSA tests?</td>
<td></td>
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<tr>
<td>Do you do regular testicular exams on yourself?</td>
<td></td>
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</tbody>
</table>

### FEMALE HISTORY  □ N/A

<table>
<thead>
<tr>
<th>Question</th>
<th>No</th>
<th>Yes</th>
<th>Age that you started having periods:</th>
<th></th>
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</thead>
<tbody>
<tr>
<td>Are you still having periods?</td>
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<td>Are they regular?</td>
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<tr>
<td>Have you had a hysterectomy?</td>
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<td>Year:</td>
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<tr>
<td>Have you had your ovaries removed?</td>
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<td></td>
<td>Why was this done?</td>
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<tr>
<td>Age at menopause:</td>
<td></td>
<td></td>
<td>Date of last menstrual period:</td>
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<tr>
<td>Do/did you use oral contraceptives?</td>
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<td>Do/did you use injectable contraceptives?</td>
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<tr>
<td>How long?</td>
<td></td>
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<td>What drug?</td>
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<tr>
<td>Do/did you take hormone replacement therapy?</td>
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<td>What drug?</td>
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<tr>
<td>Have you ever used fertility drugs?</td>
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<td>How long?</td>
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<tr>
<td>Number of pregnancies:</td>
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<td>Number of live births:</td>
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<tr>
<td>Did you breastfeed:</td>
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<td>Age at first full term pregnancy:</td>
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</tbody>
</table>

### ADVANCE DIRECTIVE

<table>
<thead>
<tr>
<th>Question</th>
<th>No</th>
<th>Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Could you be pregnant now?</td>
<td></td>
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<tr>
<td>Do you have regular mammograms?</td>
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<tr>
<td>Do you have regular PAP tests?</td>
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<tr>
<td>Do you have regular breast exams by a doctor?</td>
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<tr>
<td>Do you do regular breast self-exams?</td>
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### ABUSE ASSESSMENT

<table>
<thead>
<tr>
<th>Question</th>
<th>No</th>
<th>Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are you in a harmful physical or emotional relationship?</td>
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<tr>
<td>If yes: □ hit/kicked □ threatened □ forced to have sex □ have you been denied food, water, medicine</td>
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<tr>
<td>Other:</td>
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NAME: ____________________________  D.O.B.: ________________

**FUNCTIONAL** - Have you had any of the following problems recently?

- Difficulty with strenuous activities you were able to do before?  □ No  □ Yes
- Trouble walking?  □ No  □ Yes
- Falling?  □ No  □ Yes
- Which of these activities can you do for yourself?  □ cook  □ clean  □ bathe  □ shop  □ drive  □ dress
- Confined to bed or chair  □ less than 50% of day  □ greater than 50% of day  □ not confined
- Trouble understanding what is said to you?  □ No  □ Yes
- Trouble speaking?  □ No  □ Yes
- Able to carry on daily activities as normal  □ No  □ Yes

**PHARMACY INFORMATION**

Name of Pharmacy: ____________________________  Phone number of Pharmacy: _____________

**ALLERGIES** (include medicines, latex, food, other)  □ No known Allergies

ALLERGY TO: ____________________________  DESCRIBE THE REACTION: ____________________________

**MEDICATIONS** - List all prescription and over the counter medications, as well as herbs and supplements.

<table>
<thead>
<tr>
<th>MEDICATION NAME</th>
<th>DOSE</th>
<th>HOW OFTEN</th>
<th>ROUTE: Taken by mouth, injection, put on skin, other (please describe)</th>
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**PHYSICIANS:** Please list all of your doctors

<table>
<thead>
<tr>
<th>NAME OF DOCTOR</th>
<th>SPECIALTY</th>
<th>TELEPHONE #/FAX #</th>
<th>ADDRESS</th>
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<table>
<thead>
<tr>
<th>NAME OF DENTIST</th>
<th>TELEPHONE #/FAX #</th>
<th>ADDRESS</th>
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