PRIMARY CARE SPECIALISTS

NEW PATIENT MEDICAL QUESTIONNAIRE- ADULT

Patient's Name_____

Date of Birth_____ Age_____

Date of Visit_____

PAST HISTORY:

Do you now have or did you ever have any of the following conditions? Check the appropriate box.

[ ] Measles, Mumps, Chicken Pox	[ ] Heart Disease	[ ] Kidney Disease	[ ] High Blood Pressure
[ ] Arthritis	[ ] Heart Attack	[ ] Diabetes	[ ] High Cholesterol
[ ] Gout	[ ] Pneumonia	[ ] Liver Disease	[ ] Mental Disorder
[ ] Cancer Type_____	[ ] Sickle Cell	[ ] Asthma	[ ] HIV/ AIDS
[ ] Glaucoma	[ ] Seizures	[ ] Stroke	
[ ] Hepatitis	[ ] Anemia	[ ] Tuberculosis	

ALLERGIES:

Are you allergic to any medications or foods?_____ YES [ ] NO [ ]

If so, what medications/foods?_____

IMMUNIZATIONS: last date of the immunization

[ ] Flu _____ [ ] Pneumonia_____ [ ] Shingles_____ [ ] Tetanus-dip_____ [ ] Hep B _____

FAMILY HISTORY: Does anyone in your family (mother, father, siblings, aunts, uncles, grandparents, etc.) have any of the following conditions? Check the appropriate box.

[ ] Tuberculosis	[ ] Heart Disease	[ ] Diabetes	[ ] Hypertension (HBP)
[ ] Stroke	[ ] Kidney Disease	[ ] Sickle Cell	[ ] Cancer Type_____
[ ] Arthritis	[ ] Liver Disease	[ ] Anemia	[ ] Seizures
[ ] Stomach/Bowel Disease	[ ] AIDS/HIV	[ ] Migraines	[ ] Other_____

SOCIAL HISTORY:

1. Have you ever smoked tobacco, cigarettes, cigars? Yes [ ] No [ ]
   If yes, how much do/did you smoke per day?_____
   Number of years you have smoked?_____
   If you have quit, what year? _____
2. Have you ever drank alcohol, wine or beer? Yes [ ] No [ ]
   If yes, how much do you drink per day, week, month?_____
3. Have you ever used any recreational or illicit drugs (marijuana, cocaine, etc) Yes [ ] No [ ]
   If yes, how long have you used the drugs?_____
4. Level of education? ___grade [ ] High School Diploma [ ] GED [ ]
   ___years of college [ ] College Degree [ ] Post-college Degree (Masters, PhD) [ ]
5. What is your occupation?_____
6. Marital Status? Married [ ] Single [ ] Separated [ ] Divorced [ ] Widowed [ ]

MEDICATIONS:

List **ALL** medications and dosages that you are currently taking_____

_____

_____

_____

PREG / BIRTH / MENSTRUAL HISTORY-FEMALES ONLY

1. Last Menstrual Cycle:_____ Age when menstrual cycle began:_____
2. Are your menstrual cycles regular? Yes [ ] No [ ]
   Do you have severe cramps with your menstrual cycle? Yes [ ] No [ ]
   Any abnormal bleeding? Yes [ ] No [ ]
3. Number of pregnancies?_____ Live Births?_____ Miscarriages?_____
   Induced abortions?_____ Type of Delivery? C-Section or Vaginal_____
4. Are you currently using birth control? Yes [ ] No [ ]

SURGICAL HISTORY/HOSPITALIZATIONS:

List any hospitalizations or surgeries you have had in the past:

_____

_____

_____

HEALTH MAINTENACE:

Have you had the following? (Date/ Year)

Eye Exam _____

Mammogram_____

Colonoscopy_____

Pap smear _____

PSA _____

REVIEW OF SYSTEMS:

WITHIN THE LAST 30 DAYS, have you experienced any of the following symptoms?

GENERAL:
[ ] Tiredness/Fatigue
[ ] Fever
[ ] Night sweats
[ ] Weight gain over 10lbs
[ ] Weight loss over 10lbs

SKIN:
[ ] Change in wart/mole
[ ] Itching
[ ] New lesion
[ ] Rash

HEENT:
[ ] Headaches
[ ] Visual disturbance
[ ] Hearing loss
[ ] Ear pain
[ ] Seasonal allergies
[ ] Hoarseness

NECK:
[ ] Neck pain
[ ] Swollen glands

RESPIRATORY:
[ ] Cough
[ ] Difficulty breathing
[ ] Easily fall asleep when Sitting still
[ ] Abnormally sleepy When driving

BREAST:
[ ] Breast mass
[ ] Breast pain
[ ] Nipple discharge
[ ] Nipple pain

CARDIAC:
[ ] Chest pain
[ ] Irregular heart beat
[ ] Palpitations
[ ] Swollen extremities

GASTROINTESTINAL:
[ ] Abdominal pain
[ ] Constipation
[ ] Diarrhea
[ ] Difficult swallowing
[ ] Heart burn
[ ] Rectal bleeding

FEMALE URINARY:
[ ] Absence of menses
[ ] Blood in urine
[ ] Excessive menses bleeding
[ ] Frequent urinating
[ ] Painful menses
[ ] Painful urinating
[ ] Lot of night time urinating
[ ] Urine leakage

MALE URINARY:
[ ] Blood in urine
[ ] Erection difficulty
[ ] Frequent urinating
[ ] Painful urinating
[ ] Testicle pain
[ ] Urethral discharge
[ ] Lot of night time urinating

MUSCULOSKELATAL:
[ ] Back pain
[ ] Calf pain
[ ] Joint pain
[ ] Muscle cramps

NEURO:
[ ] Decreased memory
[ ] Dizziness
[ ] Fainting
[ ] Numbness
[ ] Tremor
[ ] Trouble walking
[ ] Vertigo
[ ] Weakness

PSYCHIATRIC:
[ ] Anxiety
[ ] Depression
[ ] Inability to concentrate
[ ] Mood changes
[ ] Nervousness

ENDOCRINE:
[ ] Cold intolerance
[ ] Excessive sweating
[ ] Excessive thirst
[ ] Heat intolerance

HEMATOLOGY:
[ ] Abnormal bleeding
[ ] Anemia
[ ] Blood clots
[ ] Easy bruising