NEW PATIENT HEALTH QUESTIONNAIRE

This information will help facilitate your initial office visit so that we may focus our time on addressing your specific health concerns. This is a confidential record and information given here will not be given out without your permission.

PATIENT NAME:_____

HEIGHT _____ WEIGHT _____ GENDER _____ DATE OF BIRTH_____

REASON FOR TODAY'S VISIT: _____

REVIEW OF SYSTEMS

Please check, if you have *a PERSONAL HISTORY* for the following:

GENERAL
- ☐ Sudden weight loss
- ☐ Sudden weight gain
- ☐ Fevers, chills, sweats
- ☐ Constipation
- ☐ Fatigue
- ☐ Night sweats

ENDOCRINE
- ☐ Excessive thirst
- ☐ Intolerance to heat
- ☐ Excessive urine
- ☐ Hair loss

GENITO-URINARY
- ☐ Blood in urine
- ☐ Incontinence
- ☐ Frequent urination
- ☐ Painful urination

NEUROLOGICAL
- ☐ Loss of balance
- ☐ Seizures
- ☐ Loss of strength
- ☐ Tingling
- ☐ Weakness

HEAD AND NECK
- ☐ Blurred vision
- ☐ Eye pain
- ☐ Eye discharge
- ☐ Nosebleeds
- ☐ Sinus problems
- ☐ Loss of hearing
- ☐ Headaches
- ☐ Dentures
- ☐ Difficulty swallowing
- ☐ Other

GASTROINTESTINAL
- ☐ Diarrhea
- ☐ Blood in stool
- ☐ Abdominal Pain
- ☐ Nausea
- ☐ Vomiting
- ☐ Gas
- ☐ Bloating
- ☐ Heartburn
- ☐ Black, tarry smelly stools

CARDIOVASCULAR
- ☐ Chest pain
- ☐ Leg pain when walking
- ☐ Swelling of legs/ankles
- ☐ Irregular heart beat
- ☐ Shortness of breath when lying down
- ☐ Other

MUSCULOSKELETAL
- ☐ Joint pain
- ☐ Joint swelling
- ☐ Back pain
- ☐ Other

SKIN
- ☐ Hives
- ☐ Itching
- ☐ Change in moles
- ☐ Rash

PSYCHIATRIC
- ☐ Anxiety
- ☐ Depression
- ☐ Psychosis

BREAST
- ☐ Lumps
- ☐ Nipple discharge
- ☐ Tenderness

RESPIRATORY
- ☐ Shortness of breath upon exertion
- ☐ Cough
- ☐ Wheezing
- ☐ Other

MEN ONLY
- ☐ Lump in testicles
- ☐ Penis discharge
- ☐ Prostate problems

LYMPHATIC
- ☐ Swollen glands

WOMEN ONLY
- ☐ Currently pregnant

Last menstrual period

__/_____/_____

# of prior pregnancies_____

Number of live births_____

☐ **PLEASE CHECK HERE TO VERIFY THAT ALL UNMARKED ITEMS ARE NEGATIVE**

PERSONAL MEDICAL HISTORY

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- ☐ HIV / AIDS
- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Blood Clots
- ☐ Cancer
- ☐ Cataracts
- ☐ Coronary Disease Heart attack, Stents, Congestive Heart Failure
- ☐ Crohn's Disease
- ☐ Diabetes
- ☐ Emphysema/COPD
- ☐ Epilepsy/Seizures
- ☐ Glaucoma
- ☐ Hepatitis
- ☐ Hypertension
- ☐ Kidney Disease
- ☐ MRSA
- ☐ Pneumonia
- ☐ Rheumatic Fever
- ☐ Sleep Apnea
- ☐ Stroke
- ☐ Tuberculosis

☐ **PLEASE CHECK HERE TO VERIFY THAT ALL UNMARKED ITEMS ARE NEGATIVE**

COMMENTS: _____

_____

FAMILY HISTORY

Check and list relationship on the line below if ANYONE IN YOUR FAMILY has a history of the following:

☐ Cancer _____ Relationship & Type

☐ Diabetes _____ Relationship

☐ Heart Disease _____ Relationship

☐ Other Problems (explain below) _____ Relationship

Please explain_____

☐ **PLEASE CHECK HERE TO VERIFY THAT ALL UNMARKED ITEMS ARE NEGATIVE**

Please complete second page of questionnaire

HOSPITALIZATIONS/SURGERIES

Please list any hospitalizations surgeries, biopsies/procedures. ☐ **Please check here if no previous surgeries.**

YEAR	HOSPITALIZATION /SURGERY	YEAR	HOSPITALIZATION/SURGERY
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

HEALTH HABITS/SOCIAL HISTORY

Check the following regarding your current or past health habits:

Tobacco use/Smoke: ☐ Yes ☐ No ☐ Former
If former, year quit:_____

Street/Recreational Drug Use: ☐ Yes ☐ No ☐ Former
If yes or former, type and year quit:_____

Alcohol: ☐ Yes ☐ No
If yes, frequency and amount_____

Exercise: ☐ Yes ☐ No
If yes, frequency and amount_____

Have you ever had an H.I.V. (AIDS) test? ☐ Yes ☐ No IF YES, the results were: ☐ Negative ☐ Positive

CURRENT MEDICATIONS

Please list all prescription and nonprescription medications. Please include all vitamins, supplements, aspirin, birth control medications, laxatives and medicines taken "as needed".

Medicine	Dose	Medicine	Dose
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

ALLERGIES

Do you have any allergies to medicines, foods, latex, iodine, contrast dye, etc.?

☐ Check if no known drug allergies. ☐ Check if no latex allergy

Please complete the following to provide us with information regarding your allergies.

Allergen	Type of Reaction	Allergen	Type of Reaction
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

To the best of my knowledge, all the information provided regarding my health is complete and correct. I understand that it is my responsibility to inform SMG General Surgery if I have any changes in my health, or health information.

_____
Patient's Printed Name

_____ _____
Signature of Patient (or Representative) Date