Innovative Clinical Research Center, Inc.

"Helping pave the way for future medicine"

NEW PATIENT QUESTIONNAIRE

Date:_____ Person filling out questionnaire, if not patient (relationship to patient):

☐ Spouse ☐ Parent ☐ Child ☐ Sibling ☐ Other: _____

Identifying Data

Name:_____Date of Birth: _____

Age:_____ Sex: ☐ Male ☐ Female Hand you write with: ☐ Right hand ☐ Left hand

Race: ☐ Caucasian ☐ African American ☐ Native American ☐ Hispanic ☐ Asian/Pacific Islander

☐ Other: _____

Nationality, if not US Citizen:_____Language spoken fluently, if not English: _____

Referring doctor:_____Primary medical doctor: _____

Pharmacy (name, location & phone): _____

Chief Complaint/Diagnosis for research study

Please briefly state your main problem (reason for visit): _____

_____

LOCATION (on body): _____

_____

QUALITY (description): _____

_____

SEVERITY: (10-very severe) ☐ 10 ☐ 9 ☐ 8 ☐ 7 ☐ 6 ☐ 5 ☐ 4 ☐ 3 ☐ 2 ☐ 1

DURATION:

☐ few seconds	☐ 30 seconds	☐ 1 minute	☐ few minutes
☐ 30 minutes	☐ 1 hour	☐ few hours	☐ 1 day
☐ few days	☐ 1 week	☐ few weeks	☐ 1 month
☐ few months	☐ constant		

TIMING: When did the problem begin? _____

How did it begin? ☐ suddenly ☐ gradually

How often does it occur?

☐ constant ☐ every few seconds ☐ every few minutes ☐ once per hour ☐ few times per hour
☐ once per hour ☐ every few hours ☐ few times per day ☐ once per day ☐ few times per week
☐ once per week ☐ few times per month ☐ once per month ☐ every few month ☐ few times a year

CONTEXT (S) in which problem occurs: _____

_____

MODIFYING FACTORS:

Things that make the problem worse: _____

Things that make the problem better: _____

ASSOCIATED SYMPTOMS:

Please list any other symptom (s) that occur with your main symptom: _____

_____

MISCELLANEOUS INFORMATION:

If the problem is a result of an injury, please provide the date of the injury and describe how it occurred:

_____

_____

_____

If you have missed work because of the problem, how much work have you missed? _____

If you have seen any other physicians about this problem, please list their name and specialty: _____

_____

Please check any test(s) you have had because of the problem and list date performed:

☐ Blood test _____ ☐ MRI _____ ☐ CT _____ ☐ EEG _____ ☐ EMG/NCS _____

☐ Lumbar puncture (spinal tap) _____

Is there anything else that we need to know about the problem? _____

_____

_____

Past Medical History

Please circle any of the following medical illnesses you have had:

Abdominal aortic aneurysm	Alcoholism	Alzheimer's disease
Anemia	Anxiety/Panic attacks	Asthma
Astigmatism	Atrial fibrillation	ADD
Benign positional vertigo	Bipolar disorder	Bladder infection
Bleeding tendency	Blindness	Blood clot-heart
Blood clot-leg	Blood clot-lung	Brain aneurysm
Brain tumor	Bronchitis	Cancer
Cardiac arrest	Carpal tunnel syndrome	Cataracts
Chiari malformation	Cirrhosis	Closed heart injury
Congestive heart failure	Coronary artery disease	Crohn's disease
Deafness	Dementia	Depression
Diabetes	Diverticulosis	Drug addiction
Ear infection	Emphysema	Encephalitis
Enlarged Prostate	Epilepsy or seizure	Essential tremor
Gall stones	Gastritis	GERD
Glaucoma	Gout	Heart arrhythmia
Heart attack	Hemorrhoids	Hepatitis
Herniated disc	Hiatal hernia	High Blood pressure
High Cholesterol	HIV/AIDS	Hydrocephalus
Irritable bowel syndrome	Kidney failure	Kidney infection
Kidney stone	ALS	Leukemia
Lupus	Lymphoma	Malabsorption
Meningitis	Mental retardation	Migraine
Mitral valve prolapsed	Multiple myeloma	Multiple sclerosis
Muscular dystrophy	Myasthenia gravis	Narcolepsy
Nasal allergies	Neurofibromatosis	Neuropathy
Obstructive sleep apnea	Optic neuritis	Osteoarthritis
Pancreatitis	Parkinson's disease	Peripheral vascular disease
Platelet disorder	Pneumonia	Polymyositis
PTSD	Pseudotumor cerebri	Psoriasis
Rheumatoid arthritis	Schizophrenia	Scoliosis
Sinus infection	Skull fracture	Spina bifida
Spinal stenosis	Stomach ulcer	Strabismus

Please list any other medical illnesses you have had not mentioned above:_____

_____

Past Surgical History

Please circle any of the following procedures you have had:

Abdominal aortic aneurysm repair	Abdominal hernia repair	Amputation
Appendectomy	Back surgery	Bladder surgery
Brain aneurysm clip or coil	Brain hematoma removed	Brain tumor removed
Brain vascular malformation removed	Breast or breast lump removed	Carotid endarterectomy
Bypass or stent of leg artery	Carpal tunnel release	Cataract surgery
Cerebrospinal fluid shunt	Colorectal surgery	Coronary bypass (CABG)
Coronary stent	Beep brain stimulator	Epilepsy surgery
Gall bladder removed	Gastric bypass	Greenfield filter
Heart valve replacement	Hiatal hernia repair	Hip replacement
Hysterectomy	Inguinal hernia repair	Kidney removed
Kidney transplant	Knee replacement	Lithotripsy
Liver transplant	Lung removed	Lung transplant
Nasal surgery	Neck surgery	Ovary removed
Pacemaker	Posterior fossa decompression	Prostate removed
Retinal photocoagulation	Sinus surgery	Small bowel surgery
Spleen removed	Strabismus surgery	Thyroid surgery
Transurethral prostate resection (TURP)	Tonsils removed	Vagus nerve stimulator

Please list any other procedures you have had not mentioned above: _____

_____

Current Medications

Medication	Dose	Frequency

Allergies

Please list all medication allergies: _____

_____

Social History

MARITAL STATUS

Currently, I am: ☐ Single, never married ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Who do you live with? ☐ Self ☐ Spouse ☐ Child ☐ Parent ☐ Sibling ☐ Other

Occupation

Do you work? ☐ Yes ☐ No If not, why? _____

How much do you work? ☐ Full-time ☐ Part-time

Job title(s): _____

EDUCATION

Are you currently enrolled in school: ☐ Yes ☐ No

If yes, where? _____

Major, if any? _____

Highest level of education obtained: _____

Degree(s) earned, if any: _____

ALCOHOL/DRUGS

Do you drink alcohol? ☐ Yes ☐ No If yes, how much? _____

If you quit drinking, how long age did you quit? _____

How much and how long did you drink? _____

Do you use illicit drugs? ☐ Yes ☐ No

If yes, please list: _____

TOBACCO

Do you smoke? ☐ Yes ☐ No If yes, how much? _____

If you quit smoking, how long ago did you quit? _____

How much and how long did you smoke? _____

Family History

Please check the members of you family that have/had the following medical illnesses:

	Father	Mother	Brother	Sister	Other (please list)
Alcoholism	☐	☐	☐	☐	☐ _____
Alzheimer's disease	☐	☐	☐	☐	☐ _____
Anemia	☐	☐	☐	☐	☐ _____
Anxiety/Panic attacks	☐	☐	☐	☐	☐ _____
Attention deficit disorder	☐	☐	☐	☐	☐ _____
Asthma	☐	☐	☐	☐	☐ _____
Bipolar disorder	☐	☐	☐	☐	☐ _____
Bleeding tendency	☐	☐	☐	☐	☐ _____
Blindness	☐	☐	☐	☐	☐ _____
Blood clot-leg	☐	☐	☐	☐	☐ _____
Blood clot-lung	☐	☐	☐	☐	☐ _____
Brain aneurysm	☐	☐	☐	☐	☐ _____
Cancer	☐	☐	☐	☐	☐ _____
Congestive heart failure	☐	☐	☐	☐	☐ _____
Coronary artery disease	☐	☐	☐	☐	☐ _____
Crohn's disease	☐	☐	☐	☐	☐ _____
Deafness	☐	☐	☐	☐	☐ _____
Dementia	☐	☐	☐	☐	☐ _____
Depression	☐	☐	☐	☐	☐ _____
Diabetes	☐	☐	☐	☐	☐ _____
Drug addiction	☐	☐	☐	☐	☐ _____
Epilepsy or seizure	☐	☐	☐	☐	☐ _____
Essential tremor	☐	☐	☐	☐	☐ _____
Gout	☐	☐	☐	☐	☐ _____
Heart attack	☐	☐	☐	☐	☐ _____
High blood pressure	☐	☐	☐	☐	☐ _____
High cholesterol	☐	☐	☐	☐	☐ _____
Kidney failure	☐	☐	☐	☐	☐ _____
Kidney stones	☐	☐	☐	☐	☐ _____
Leukemia	☐	☐	☐	☐	☐ _____
Lou Gehrig's disease (ALS)	☐	☐	☐	☐	☐ _____
Lupus	☐	☐	☐	☐	☐ _____
Lymphoma	☐	☐	☐	☐	☐ _____

	Father	Mother	Brother	Sister	Other (please list)
Mental retardation	☐	☐	☐	☐	☐_____
Migraine	☐	☐	☐	☐	☐_____
Multiple sclerosis	☐	☐	☐	☐	☐_____
Muscular dystrophy	☐	☐	☐	☐	☐_____
Narcolepsy	☐	☐	☐	☐	☐_____
Neuropathy	☐	☐	☐	☐	☐_____
Parkinson's disease	☐	☐	☐	☐	☐_____
Peripheral vascular disease	☐	☐	☐	☐	☐_____
Psoriasis	☐	☐	☐	☐	☐_____
Rheumatoid arthritis	☐	☐	☐	☐	☐_____
Schizophrenia	☐	☐	☐	☐	☐_____
Stroke of TIA	☐	☐	☐	☐	☐_____
Thyroid disease	☐	☐	☐	☐	☐_____
Ulcerative colitis	☐	☐	☐	☐	☐_____

Please list any other medical illnesses in your family (and the family members that have/had them) not mentioned above:

_____

_____

_____

Review of Systems

Please review the following lists of symptoms and circle any of those that you have experienced ***recently.***

CONSITITUTIONAL
Recent weight gain
Resent weight loss
Fatigue
Weakness of entire body
Fever
Chills
Sweats

EYES
Loss of vision
Double or blurred vision
Pain
Redness
Dryness
Feels like something in eye

EARS, NOSE, MOUTH, THROAT
Ear pain
Loss of hearing
Ringing in ears
Nosebleeds
Loss of smell
Swollen or bleeding in gums
Sore tongue
Loss of taste
Sores in mouth
Dry mouth
Sore throat
Hoarseness
Swollen glands in neck

CARDIOVASCULAR
Blood pressure
Heart murmurs
Chest pain
Feel heart beating in chest
Fast or slow heart beat
Irregular heart beat
Swelling in legs or feet

RESPIRATORY
Cough
Coughing up phlegm
Coughing up blood
Wheezing
Shortness of breath
Difficulty breathing at night
Snoring

GASTROINTESTINAL
- Difficulty swallowing
- Heartburn
- Decreased appetite
- Nausea
- Vomiting
- Vomiting of blood
- Blood in stool or black stools
- Constipation
- Diarrhea
- Abdominal pain
- Indigestion or gas
- Jaundice

GENITOURINARY
- Frequent urination
- Urination more than twice during the night
- Pain or burning with urination
- Blood in urine
- Difficulty urinating
- Loss of bladder control

MUSCULOSKELETAL
- Muscle pain
- Muscle spasm
- Joint pain
- Joint stiffness
- Joint swelling
- Neck pain
- Back pain
- Difficulty walking

INTEGUMENTARY (SKIN)
- Sensitivity to sun
- Rash
- Hives
- Itching
- Dryness
- Tightness
- Discoloration
- Sores
- Lumps
- Hair loss
- Changes in nails

NEUROLOGICAL
- Headaches
- Dizziness
- Loss of consciousness
- Seizures
- Weakness in extremity
- Pain in extremity
- Numbness
- Tingling
- Tremor
- Memory loss
- Difficulty speaking

PSYCHIATRIC
- Depression
- Anxiety or nervousness
- Stress
- Insomnia
- Excessive daytime sleepiness
- Euphoria or elation
- Hallucinations

ENDOCRINE
- Heat or cold intolerance
- Increased appetite
- Increased thirst

HEMATOLOGIC/LYMPHATIC
- Easy bruising
- Excessive bleeding
- Swollen lymph nodes

ALLERGIC/IMMUNOLOGIC
- Sneezing
- Runny nose
- Nasal or sinus congestion
- Watery eyes

Signature:_____ Date: _____

Thank you for filling out this questionnaire. Your cooperation is greatly appreciated. This information will help us provide the best possible healthcare for you or your loved one.

Sincerely,

Innovative Clinical Research Center