New Adult Patient Questionnaire

Patient Name: _________________________________ Date: _______ Age: ______

Referred by:  □ Physician: _________________________________  ____________________
□ TV ad  □ Internet  □ Another patient  □ Other: ____________________________

Reason for today’s visit:
________________________________________________________________________
________________________________________________________________________

PAST MEDICAL / SURGICAL HISTORY

Have you ever had any of the following medical problems?
□ High blood pressure  □ Stroke  □ Acid regurgitation (GERD)  □ Tuberculosis
□ Heart attack  □ Diabetes  □ Cancer (type): _________  □ Bleeding disorder
□ Asthma  □ Hepatitis  □ Psychiatric treatment  □ Blood clot (DVT / PE)
□ COPD / emphysema  □ Prostate problems  □ Arthritis (specify site(s)): _________

List any other major illnesses and/or injuries, other than the reason for today’s visit:
________________________________________________________________________
________________________________________________________________________

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<thead>
<tr>
<th>Surgeries/Hospitalizations</th>
<th>Year</th>
<th>Complications</th>
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Have you ever had a problem with anesthesia? □ No □ Yes (describe) ____________________

______________________________________________________________________________

MEDICATIONS

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<th>Current Medications</th>
<th>Dose</th>
<th>Frequency</th>
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If not already listed above, do you regularly take any blood thinners? (circle any)
Aspirin Ibuprofen (Motrin, Aleve, etc.) Coumadin Plavix Other ______

Have you taken oral steroids (ex. prednisone, medrol) within the past year? Yes No

ALLERGIES

Allergies to Medications: □ Yes □ No
If yes, please list including type of reaction.

Any allergy to medical tape, iodine, or latex? □ Yes (describe) ____________________ □ No

Have you ever had Allergy Skin testing? □ Yes □ No
If “yes” what allergies were detected? ____________________

Have you ever had Allergy Shots (Immunotherapy)? □ Yes □ No If “yes” did it help? □ Yes □ No

SOCIAL HISTORY

Current occupation (or most recent, if not currently working): ____________________

Occupational Status: □ Employed □ Homemaker □ Unemployed □ Retired (year) ______
□ Student (where): ____________________ □ Disabled (reason) ____________________

Marital Status: □ Single □ Married □ Divorced □ Widowed
Who lives at home with you? ____________________
Do you have children? □ Yes (Please list their ages if under 18) ____________________ □ No

Do you currently smoke? □ Yes □ No Have you ever smoked in the past? □ Yes □ No
At what age did you start smoking? ______ At what age did you stop smoking? ______
Products used: □ Cigarettes □ Cigars □ Pipe □ Chewing tobacco □ Marijuana
How often (e.g. # of packs per day)? ____________________
Any exposure to second-hand smoke? □ Yes □ No Describe: ____________________

Do you drink alcoholic beverages? □ Yes □ No If so, how often? ____________________
Any history of alcohol abuse? □ Yes □ No If so, give approximate dates ____________
FAMILY HISTORY

Mother’s age: ____  □ Alive  □ Deceased - cause of death ________________________  
Father’s age: ____  □ Alive  □ Deceased - cause of death ________________________  

Any significant diseases that run in the family? (please specify which relative)

□ Allergy  □ Asthma  □ Bleeding disorder  □ Cystic Fibrosis  □ Heart Disease  
□ Immunodeficiency  □ Cancer (specify type): _____________  □ Other: __________
  ____________________________________________________________________________

REVIEW OF SYSTEMS

Please check all symptoms which you are currently experiencing or have experienced in the past month:

CONSTITUTIONAL

□ Unintentional weight loss: ____ pounds in the past ___ weeks  □ Fever, chills

EYES:  ENT:
□ Double vision  □ Hearing loss  □ Nose drainage  □ Swallowing pain
□ Loss of vision  □ Ringing in ears  □ Nasal congestion  □ Voice change / loss
□ Eye pain  □ Ear pain  □ Facial pain  □ Throat clearing
□ Ear drainage  □ Sore mouth/throat  □ Hoarseness

CARDIOVASCULAR:  PULMONARY:  GASTROINTESTINAL:
□ Chest pain  □ Shortness of breath attack  □ Heartburn
□ Irregular heartbeat  □ Wheezing  □ Difficulty swallowing liquids
□ Leg pain during walking  □ Coughing up blood  □ Difficulty swallowing solids
□ Swelling of legs or feet  □ Chronic cough  □ Nausea / vomiting (circle which)

GENITOURINARY:  MUSCULOSKELETAL:  PSYCHIATRIC:
□ Blood in urine  □ Neck pain  □ Depression
□ Pain during urination  □ Back pain  □ Nervous / anxious
□ Difficulty urinating  □ Joint pain  □ Substance abuse

NEUROLOGICAL:
□ Headaches  □ Speech problems  □ Seizure  □ Weakness
□ Memory Loss  □ Numbness  □ Tingling  □ Dizziness

The above information is accurate to the best of my knowledge.

X _____________________________________________  ____________________________
  Patient Signature  Date

For Physician Use Only:

I have reviewed the above information with the patient.

______________________________________________________________________________

Physician Name & Signature  Date