



NEW PATIENT QUESTIONNAIRE

Last Name: _____ First Name: _____ Middle Initial:

Date Form Completed: _____ Referring Physician:

Address: _____ City: _____ State: _____ Zip:

DOB: _____ Age: _____ Sex: Male Female

Marital Status: Married Single Divorced Separated Widowed

Race: Caucasian African American Hispanic Other

What is the reason for your visit?

Please leave blank:

Office Use Only: flu shot provided pneumovax provided inhaler instruction provided
 smoking cessation counseling 2 – 10 min smoke cessation counseling > 10 min

Patient Name: _____

DOB: _____

YOUR PERSONAL PAST MEDICAL HISTORY

Please check the following symptoms and/or conditions that pertain to your past medical history:

- Anemia
- Angina Pectoris
- Anxiety Disorder
- Arrhythmias/Rhythm Disorder
- Asthma
- Atrial Fibrillation
- BiPAP used in home
- Bronchiectasis
- Bronchitis
- Cancer
- Cerebral Artery Disease
- Clotting/Bleeding Disorder
- Congestive Heart Failure
- COPD
- Coronary Artery Disease
- CPAP used in home
- Cough
- Cystic Fibrosis
- Depression
- Diabetes Mellitus
- Emphysema
- Heart Attack
- Hepatitis
- High Blood Pressure
- High Cholesterol
- Histiocytosis
- HIV/AIDS
- Insomnia
- Irritable Bowel Syndrome
- Kidney Disease
- Liver Dysfunction
- Obstructive Sleep Apnea
- Osteoarthritis
- Peptic Ulcer Disease
- Pneumonia
- Pulmonary (Lung) Fibrosis or scarring
- Reflux (Heartburn or GERD)
- Rheumatoid Arthritis
- Sarcoidosis
- Seizures
- Sinusitis
- Stroke
- Systemic Lupus
- Thyroid Disease
- Tuberculosis
- Vascular Disease
- Weakness
- Wegener's Disease
- Other _____

PAST SURGERIES

Year	Procedure
_____	_____
_____	_____

Patient Name: _____

DOB: _____

SOCIAL HISTORY

CIGARETTE SMOKING HISTORY

- Never Smoked
- I smoked an average of _____ packs per day starting at age _____ and [last smoked at age _____] or [continue to smoke]. During this time frame, the most I smoked was _____ packs per day and the least I smoked was _____ packs per day. The longest I quit was for _____ years _____ months. {transcribe: avg, range, start, end, #yrs, p-yrs, other}
- Smoked Other Tobacco Products

ALCOHOL HISTORY

- Never Drink Alcohol
- Drink Socially
- Drink Alcohol Regularly (_____ # Drinks Per Day)
- Reformed Drinker

RECREATIONAL DRUG USE

- Please specify drug(s): _____
- Previous • Current • Inhaled • Injected

EXPOSURE HISTORY

- Pets in home (list number and type): _____
- Asbestos Exposure (from age _____ to age _____ circle one: light/medium/heavy)
- Unusual or Recent Travel (last 6 months outside of Midatlantic area): _____
- Other Occupational Exposures (**circle those that apply**)
 - Inorganic dusts: quarries, sandblasting, cement, stone carving, welding, plumbing, shipyard work, firefighter, silica, coal dust, other (_____)
 - Organic dusts: birds, farming, building inspection, woodworking, remodeling, handling vegetable matter, animals, other (_____)

EDUCATION

- Through _____ Grade
- Completed High School
- Completed College
- Post Graduate

OCCUPATIONAL HISTORY

Occupation: _____ Employer: _____ Retired: Yes / No

VACCINATION HISTORY

- Pneumonia Vaccine (last received _____)
- Flu Vaccine (last received _____)

Patient Name: _____

DOB: _____

REVIEW OF SYSTEMS

Please indicate whether you have recently, previously or never experienced any of the following symptoms:

	Now	Prior	Never
General			
Change in Weight			
Eczema			
Loss of Appetite			
Chills			
Fatigue			
Fever			
Night Sweats			
Sweats			
Lungs and Chest			
Coughing			
Coughing Blood			
Coughing Mucous			
Oxygen Use			
Shortness of Breath			
Wheezing			
Stomach and Bowel			
Abdominal Pain			
Bloody/Dark Stools			
Heartburn/Indigestion			
Nausea			
Trouble Swallowing			
Vomiting			
Vomiting Blood			
Ears, Nose, Throat			
Cold Symptoms			
Hearing Difficulty			
Hoarseness			
Nasal Problems			
Sinus Problems			
Sore Throat			
Sleep			
Excessive Sleepiness			
Insomnia			
Snoring			
Stop Breathing Night			

	Now	Prior	Never
Heart/Blood Vessels			
Black Out Spells			
Chest Pain			
Fast or Irregular Pulse			
Leg or Ankle Swelling			
Leg Pain with Walking			
Palpitations			
Awaken Out of Breath			
Nerves and Brain			
Arm or Leg Weakness			
Dizziness/Fainting			
Frequent Headaches			
Numbness/Tingling			
Stroke/Paralysis			
Blood/Lymph Nodes			
Enlarged Lymph Nodes			
Excess Bruising/Bleeding			
History of Blood Clot			
Muscle/Bones/Joint			
Aches			
Arthritis			
Back Pain			
Chest Wall Pain			
Joint Stiffness or Swelling			
Mental Illness			
Alcohol Addiction			
Anxiety			
Bipolar			
Depression			
Substance Addiction			
Schizophrenia			
Endocrine			
Excessive Thirst			
Excessive Urination			
Intolerance to Heat/Cold			
Thyroid Problems			

Trouble Falling Asleep			
Trouble Staying Asleep			

Urinary			
Prostate problems			
Stones, blood in urine			

Patient Name: _____

DOB: _____

FAMILY HISTORY

Please check the following conditions that pertain to your family history:

Mother: Alive (current age _____) or Deceased (at age _____)

Mother's Medical Problems:

Father: Alive (current age _____) or Deceased (at age _____)

Father's Medical Problems:

Sister: Alive (current age _____) or Deceased (at age _____)

Sister's Medical Problems:

Brother: Alive (current age _____) or Deceased (at age _____)

Brother's Medical Problems:

Daughter: Alive (current age _____) or Deceased (at age _____)

Daughter's Medical Problems:

Son: Alive (current age _____) or Deceased (at age _____)

Son's Medical

Problems: _____

Other Pertinent Family History if applicable: _____

PHYSICIAN VERIFICATION

I have personally reviewed the New Patient Questionnaire for this patient.

Physician's Signature: _____