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
- ☐ Anxiety / Depression
- ☐ Arrhythmias
- ☐ Asthma
- ☐ Bronchiectasis
- ☐ Bronchitis
- ☐ Cancer
- ☐ Cerebral Artery Disease
- ☐ Clotting/Bleeding Disorder
- ☐ Congestive Heart Failure
- ☐ COPD
- ☐ Coronary Artery Disease
- ☐ CPAP or BiPAP used at home?
- ☐ Cystic Fibrosis
- ☐ 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
- ☐ 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: ____________

MEDICATIONS

Please list all medications that you are currently taking, including vitamins, supplemental herbs, and over-the counter medications.

	Medication	Dosage	Frequency
Example:	Zantac	150 mg.	Twice per day

ALLERGIES

☐ Medications: *(Please specify medication allergy and type of reaction)*________________________
____

☐ Seasonal/Environmental Allergies: ____

☐ Other: ____

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)***
  - o Inorganic dusts: quarries, sandblasting, cement, stone carving, welding, plumbing, shipyard work, firefighter, silica, coal dust, other (____________________________)
  - o 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			
Trouble Falling Asleep			
Trouble Staying Asleep			

	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			
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: ____

Siblings: # Alive ______ # Deceased ______

Sibling's Medical Problems: ____

____

Children: # Alive ______ # Deceased ______

Children'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: _______________________________________