New Patient Health Questionnaire

Patient: _____ Date of birth: _____ /_____ /_____ Age: _____

Please **INDICATE** *the reasons for* today's visit**.**

1._____

Immunizations:	**Yes**	**No**	**(if so, when)**
Have you had the Flu shot this Flu Season?			
Have you had the Pneumococcal vaccine?			

Medication Name	**Dosage**	**Frequency**
Medication Allergies:		

Past Medical History	**YES**	**NO**	**NOTES**
Heart Attack			
Stroke/TIA			
High Blood Pressure			
High Cholesterol			
Thyroid Problem			
Kidney Failure			
Coronary Artery Disease			
Peripheral Vascular Disease			
Cancer			
Diabetes			
DVT			
COPD			
Blood Disorders			

Procedures	**Yes**	**No**	**Year**	**Notes**
Heart Cath/Angioplasty / Stent				
Pacemaker/Defibrillator				
Prior Hemodialysis Catheters				
Prior Fistula				
Prior Graft				
Amputations – If Yes, please indicate location				

New Patient Health Questionnaire

Surgeries/Hospitalizations	Year
1.	
2.	
3.	
4.	
5.	

Family Health History	Relationship	If deceased, age of death
Heart Disease		
Stroke		
High Blood Pressure		
High Cholesterol		
Tuberculosis		
Kidney Disease		
Emphysema		
Cancer		

Social History
***Marital Status*:** Married Separated Divorced Widowed Single
Smoking: Have you previously smoked? Yes No Currently smoking #of _____packs/day
Alcohol: Do you drink alcohol? Yes No How many glasses a week _____ of wine beer liquor
Caffeine: Do you drink caffeine? Yes No
Exercise: Do you exercise? Yes No How many times a week _____

Review of Systems (Circle all that apply)		Yes	No
Cardiovascular:	Irregular Heart Beat/palpitation -Swelling feet, ankles or hands		
Constitutional:	Weight changes -- Fatigue -- Difficulty sleeping		
Hematology:	Easy Bruising -- Frequent bleeding -- Anemia		
Musculoskeletal:	Leg muscle stiffness Weakness of leg muscles--Difficulty in walking		
Neurological:	Headaches -- Numbness/tingling -- Blurred vision -- Dizziness -- Memory loss		
Respiratory:	Shortness of breath – Cough -- Snoring		
Skin:	Eczema -- Frequent itching -- Rash		
Urinary:	Burning -- Bloody -- Painful -- Frequency -- Urgency -- Infections		
Psychiatry:	Chronic stress/depression -- Mood swings -- Irritable		
Gastrointestinal:	Nausea/vomiting -- Constipation/diarrhea -- Blood in stool		
Ear, Nose, Throat:	Ringing in ear -- Hearing problems -- Frequent nose bleeds		
Eyes:	Vision changes		

I have provided the above medical history and verify that it is accurate and complete:

Patient Signature: _____ Date: _____

Physician Signature: _____ Date: _____