CARTI

TO BE SCANNED

New Patient History Questionnaire

Patient Name_____Today's Date _____ MRN_____

Gender (Please circle) Male or Female DOB _____ Height_____ Weight_____

Primary Care Physician _____Referring Physician_____

Other Treating Physicians _____

What is the main reason for your visit?_____

How long have you had this problem? _____

Tell us about your symptoms:

What is your reason for referral to CARTI?_____

How long have you had this issue?_____

_____

Can you describe the symptoms that are troubling you?_____

Do you have pain? ❍ yes ❍ no If yes, where is the pain located?_____

What does the pain feel like? ❍ Dull ❍ Sharp

On a scale of 1 to 10, how would you rate the pain? _____

Any other signs or symptoms?_____

Physician Notes: _____

_____

_____

_____

_____

_____

Physician Signature_____ Date_____

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Patient Name_____ DOB _____

Past Medical History

Please indicate all applicable medical conditions. Please circle **Yes** or **No** for each condition listed.

VASCULAR

High Blood Pressure	Y	N
Heart Attack/Date:	Y	N
Heart Rhythm Problems	Y	N
Mitral Valve Prolapse	Y	N
Congestive Heart Failure	Y	N
Cardiac Septal Defects	Y	N
Rheumatic Fever	Y	N
Stroke or TIA's/Date:	Y	N
Anemia	Y	N
Deep Vein thrombosis/Date:	Y	N
Other:	Y	N

CANCER

Head &/or Neck Date: Type:	Y	N
Skin/Date:	Y	N
Lung/Date:	Y	N
Colon/Date:	Y	N
Prostate/Date:	Y	N
Breast/Date:	Y	N
Lymphoma/Date:	Y	N
Radiation/Date:	Y	N
Chemotherapy/Date:	Y	N
Other/Type: Date:		

ENDOCRINE

Diabetes Type 1	Y	N
Diabetes Type 2	Y	N
Hypothyroid	Y	N
Hyperthyroid	Y	N

AUTOIMMUNE/CONNECTIVE TISSUE

Rheumatoid Arthritis	Y	N
Lupus	Y	N
Scleroderma	Y	N
Other:		

RESPIRATORY

Sleep Apnea	Y	N
CPAP Use	Y	N
Pneumonia/Date:	Y	N
Asthma	Y	N
Home Oxygen	Y	N

GASTRO-INTESTINAL

GERD (Reflux)	Y	N
Cirrhosis of Liver	Y	N
Hepatitis [A] [B] [C]	Y	N
Hiatal Hernia	Y	N
Ulcers	Y	N
Other:		

RENAL (KIDNEY)

Renal Failure	Y	N
Kidney Stones	Y	N
BPH	Y	N
Other:		

GYNECOLOGIC/OBSTETRIC

Number of Pregnancies		
Number of Live Births		
Age of menses onset		
Age of menopause Please circle one: Surgical or Natural		

OTHER

Glaucoma	Y	N
Seizures	Y	N
Hearing Loss	Y	N
Migraines	Y	N
HIV/Aids	Y	N
Fibromyalgia	Y	N
Other:		

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Past Surgical History

Have you ever had surgery? Yes or No

Please check all that apply to you. For all procedures checked, indicate approximate date.

CARDIOTHORACIC

☐	Coronary Artery bypass/Date:
☐	Stent Placement/Date:
☐	Pacemaker/Date:
☐	Defibrillator/Date:
☐	Valve Replacement/Date:
☐	Carotid Endarterectomy/Date:
☐	Lung Surgery/Date:
☐	Lobectomy/Date:
☐	Area?
☐	Other:

GASTROENTEROLOGY

☐	Gastric Bypass/Date:
☐	Gall Bladder/Date:
☐	Hiatal Hernia Repair/Date:
☐	Appendectomy/Date:
☐	Colectomy/Date:
☐	Other:

ORTHOPEDIC

☐	Knee Replacement/Date:
☐	Hip Replacement/Date:
☐	Neck/Spine Surgery/Date:
☐	Back Surgery/Date:
☐	Other:

EAR, NOSE, THROAT

☐	Ear Surgery/Date:
☐	Ear Tubes/Date:
☐	Tonsillectomy/Date:
☐	Adenoidectomy/Date:
☐	Sinus Surgery/Date:
☐	Nasal Surgery/Date:
☐	Tracheal Surgery/Date:
☐	Laryngeal Surgery/Date:
☐	Thyroid Surgery/Date:
☐	Throat Surgery/Date:
☐	Other:

OTHER SURGERY

☐	Craniotomy/Date:
☐	Cancer Surgery/Date:
☐	Tubal Ligation/Date:
☐	Hysterectomy/Date:
☐	EGD/Date:
☐	Aortic Aneurysm/Date:
☐	Mastectomy/Date: Left, Right, or Bilateral? Unspecified
☐	Lumpectomy/Date: Left, Right, or Bilateral? Unspecified
☐	Other:

Additional information regarding surgical history:

****Please be sure to indicate ALL prosthetics and surgical implants.

Immunization History: Please circle **Yes** or **No** and explain for eact that is applicable.

Vaccination Received			Date of vaccination
Influenze (flu shot)	Y	N	
Pneumovax	Y	N	
Varicella (Herpes Boster, Chickenpox)	Y	N	
Hepatitis [A] [B]	Y	N	
Other:	Y	N	

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Medications: Do you take ANY medications? Yes or No

List all current prescription and over the counter medications.

Medication Name	Dosage/Frequency	Reason for taking this medication	Start Date

Are you taking any supplements or herbal medications? Yes or No *Check all that apply to you.*

☐	Vitamin E	☐	St. John's Wort	☐	Feverfew	☐	Vitamin B-12
☐	Garlic	☐	Gingko Biloba	☐	Fish oil/Omega 3	☐	Other:
☐	Ginger	☐	Ginseng	☐	Multi-Vitamin		

***** Your Preferred Pharmacy:**_____

Pharmacy Address _____ Pharmacy Phone_____

Allergies:

Please check **ALL** allergies you have and *describe your reaction.*

☐	None, I have NO allergies	☐	Morphine:
☐	Acetaminophen (Tylenol):	☐	Penicillin:
☐	Aspirin:	☐	Sulfonamides:
☐	Cephalosporin:	☐	Tetracycline:
☐	Codeine:	☐	Benadryl:
☐	Demerol:	☐	Steroids:
☐	Erythromycin:	☐	Latex Allergy:
☐	Hydrocodone:	☐	Shellfish:
☐	Ibuprofen (Advil):	☐	Other:
☐	Iodine/X-ray dye:		

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Health Maintenance: Please circle Yes or No and explain for each that is applicable.

Y	N	Have you ever had previous problems with ANESTHESIA? Describe:
Y	N	Do you BRUISE or BLEED excessively when cut? Describe:
Y	N	Have you ever had a SLEEP STUDY? Most recent date tested:
		Results?
Y	N	Have you ever had a COLONOSCOPY? Most recent date tested:
		Results?
Y	N	Have you ever had an EGD? Most recent date tested:
		Results?
Y	N	Have you ever had a MAMMOGRAM? Most recent date tested:
		Results?
Y	N	Have you ever had a PAP SMEAR? Most recent date tested:
		Results?

Family History: Check which statement applies to you.

Family History of Cancer or Blood Disorder: ☐ _____ Family History Unknown ☐ _____

If you have family history of cancer: List relationship, cancer type or blood disorder, age at diagnosis, age at death and cause of death if applicable.

Relationship	Cancer type or blood disorder	Age at diagnosis	Age at death

New Patient History Questionnaire

Patient Name_____ DOB _____

Histories and Risk Factors Please circle Yes or No and explain for each that is applicable.

Alcohol

Do you use alcohol? Please circle Yes or No
How many drinks per week? _____
What type of alcohol? _____

Tobacco

- Current every day smoker? Y or N
  Age you started? _____
- Current occasional smoker? Y or N
- Former Smoker? Y or N
- Age you quit? _____
- Never Smoked _____
- Have you had smoking cessation counseling?
  Y or N

Packs/day? _____
Tobacco type used:
___Cigarettes
___Cigars
___Pipe
___Smokeless Tobacco
___E-Cigarettes
___Vapor

Drugs

- Do you currently use recreational or street drugs? (marijuana, cocaine, heroin, amphetamines, etc.) Y or N
- Have you used drugs in the past? Y or N
- What drugs have you used in the past?_____

_____

- Have you ever given yourself street drugs with a needle? (Intravenous drugs)? Y or N

Social Support

- Local family or friends available for support? Y or N

Please list:_____

_____

Diet

- Are you on a special diet? Y or N
- If yes, please explain:

Diabetic diet? Cardiac diet? Soft foods? Other?

Exercise

- Do you exercise? Y or N
- How often do you exercise? _____ What type of exercise? _____

Work & Education

- Do you work? Y or N
- What type of work do you do? (type of occupation) _____
- Are you retired? Y or N
- Are you on disability? Y or N Reason for disability?_____
- What is your education level? (Circle One)

Grade School High School Vocational School College Graduate School

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Please circle Yes or No for each condition listed.

General

Fatigue	Y	N
Low Energy Level	Y	N
Fever	Y	N
Chills	Y	N
Pain	Y	N
Weight Gain	Y	N
Weight Loss	Y	N
Loss of Appetite	Y	N

Eyes

Double Vision	Y	N
Excessive Tearing	Y	N
Impaired Vision	Y	N
Redness	Y	N
Light Sensitivity	Y	N

Skin

Nodules	Y	N
Rash	Y	N
Dry Skin	Y	N
Radiation Therapy Effect	Y	N
Nail Changes	Y	N

Breast

Breast Mass	Y	N
Breast Pain	Y	N
Nipple Discharge	Y	N

Neurologic

Abnormal Gait	Y	N
Confusion	Y	N
Dizziness	Y	N
Headache	Y	N
Memory Loss	Y	N
Numbness & Tingling	Y	N
Paralysis	Y	N
Seizures	Y	N

Cardiovascular

Difficulty breathing while lying down	Y	N
Fainting or lightheadedness	Y	N
Chest Pain	Y	N
Heart Racing	Y	N
Swelling (legs or feet)	Y	N

Respiratory

Cough	Y	N
Coughing up Blood	Y	N
Shortness of Breath	Y	N
Cough with Sputum	Y	N
Wheezing	Y	N
Pain with Breathing	Y	N

Ear/Nose/Throat

Earache	Y	N
Nose Bleeds	Y	N
Hoarseness	Y	N
Sore Throat	Y	N
Difficulty Swallowing	Y	N
Mouth Sores	Y	N
Dry Mouth	Y	N
Altered Taste	Y	N
Balance Issues	Y	N
Loss of Hearing	Y	N
Ringing in Ears	Y	N
Congestion	Y	N
Bleeding Gums	Y	N

Gastroenterology

Abdominal Cramping	Y	N
Changes in Bowel Habits	Y	N
Constipation	Y	N
Diarrhea	Y	N
Dark/Black Stools	Y	N
Nausea	Y	N
Vomiting	Y	N
Heartburn	Y	N
Jaundice	Y	N

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Hematology

Prolonged Bleeding	Y	N
Painful Lymph Nodes	Y	N
Easy Bruising	Y	N
Swollen Glands	Y	N

Psychiatric

Anxiety	Y	N
Depression	Y	N
Insomnia	Y	N
Poor Concentration	Y	N
Mood Swings	Y	N

Endocrine

Cold Intolerance	Y	N
Heat Intolerance	Y	N
Increased Sweating	Y	N
Excessive Thirst	Y	N

Gynecologic

Abnormal Menstrual Periods	Y	N
Abnormal Vaginal Bleeding	Y	N
Vaginal Discharge	Y	N
Pelvic Pain	Y	N
Sexual Dysfunction	Y	N
Vaginal Dryness	Y	N

Musculoskeletal

Joint Pain	Y	N
Joint Stiffness	Y	N
Back Pain	Y	N
Bone Pain	Y	N
Muscle Pain/Weakness	Y	N

Genitourinary

Burning on Urination	Y	N
Blood in Urine	Y	N
Increased Urination	Y	N
Urinary Hesitancy	Y	N

Allergy/Immunology

Eczema	Y	N
Frequent Infections	Y	N
Respiratory Infections	Y	N
Seasonal Allergies	Y	N

Patient's Signature **Date**