



# 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 \_\_\_\_\_

## New Patient History Questionnaire

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:	Y	N
Type:		
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:		

## New Patient History Questionnaire

Patient Name \_\_\_\_\_ DOB \_\_\_\_\_

### 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:

#### 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:

#### GASTROENTEROLOGY

Gastric Bypass/Date:
Gall Bladder/Date:
Hiatal Hernia Repair/Date:
Appendectomy/Date:
Colectomy/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?
Lumpectomy/Date: Left, Right, or Bilateral?
Other:

#### ORTHOPEDIC

Knee Replacement/Date:
Hip Replacement/Date:
Neck/Spine Surgery/Date:
Back Surgery/Date:
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 each that is applicable.

#### Vaccination Received

#### Date of vaccination

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

## New Patient History Questionnaire

Patient Name \_\_\_\_\_ DOB \_\_\_\_\_

**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.*

<input type="checkbox"/>	Vitamin E	<input type="checkbox"/>	St. John's Wort	<input type="checkbox"/>	Feverfew	<input type="checkbox"/>	Vitamin B-12
<input type="checkbox"/>	Garlic	<input type="checkbox"/>	Gingko Biloba	<input type="checkbox"/>	Fish oil/Omega 3	<input type="checkbox"/>	Other:
<input type="checkbox"/>	Ginger	<input type="checkbox"/>	Ginseng	<input type="checkbox"/>	Multi-Vitamin	<input type="checkbox"/>	

**\*\*\* Your Preferred Pharmacy:** \_\_\_\_\_

Pharmacy Address \_\_\_\_\_ Pharmacy Phone \_\_\_\_\_

### Allergies:

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

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

## New Patient History Questionnaire

Patient Name \_\_\_\_\_ DOB \_\_\_\_\_

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.

<b>Alcohol</b>	Do you use alcohol? _____ Please circle Yes or No How many drinks per week? _____ What type of alcohol? _____
<b>Tobacco</b>	<ul style="list-style-type: none"> <li>• Current every day smoker? Y or N Age you started? _____</li> <li>• Current occasional smoker? Y or N</li> <li>• Former Smoker? Y or N</li> <li>• Age you quit? _____</li> <li>• Never Smoked _____</li> <li>• Have you had smoking cessation counseling? Y or N</li> </ul> <div style="float: right; text-align: right;">             Packs/day? _____              Tobacco type used:              ___ Cigarettes              ___ Cigars              ___ Pipe              ___ Smokeless Tobacco              ___ E-Cigarettes              ___ Vapor           </div>
<b>Drugs</b>	<ul style="list-style-type: none"> <li>• Do you currently use recreational or street drugs? (marijuana, cocaine, heroin, amphetamines, etc.) Y or N</li> <li>• Have you used drugs in the past? Y or N</li> <li>• What drugs have you used in the past? _____</li> <li>• Have you ever given yourself street drugs with a needle? (Intravenous drugs)? Y or N</li> </ul>
<b>Social Support</b>	<ul style="list-style-type: none"> <li>• Local family or friends available for support? Y or N</li> </ul> Please list: _____ _____
<b>Diet</b>	<ul style="list-style-type: none"> <li>• Are you on a special diet? Y or N</li> <li>• If yes, please explain: Diabetic diet?    Cardiac diet?    Soft foods?    Other?</li> </ul>
<b>Exercise</b>	<ul style="list-style-type: none"> <li>• Do you exercise? Y or N</li> <li>• How often do you exercise? _____ What type of exercise? _____</li> </ul>
<b>Work &amp; Education</b>	<ul style="list-style-type: none"> <li>• Do you work? Y or N</li> <li>• What type of work do you do? (type of occupation) _____</li> <li>• Are you retired? Y or N</li> <li>• Are you on disability? Y or N    Reason for disability? _____</li> <li>• What is your education level? (Circle One) Grade School    High School    Vocational School    College    Graduate School</li> </ul>

## New Patient History Questionnaire

Patient Name \_\_\_\_\_ DOB \_\_\_\_\_

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

## New Patient History Questionnaire

Patient Name \_\_\_\_\_ DOB \_\_\_\_\_

### 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**