



## New Patient Information Questionnaire

### Page I: Reason for Visit

How old are you? \_\_\_\_\_ Years Old      Gender:  Male  Female

My pain is on the:  Right  Left  Both Sides

**What is the reason for today's visit? Please give complete details of your symptoms.**

---

---

---

---

**Was this the result of an accident?**

---

**What treatments have you had?**

---

---

---

---

---

**I have reviewed this document in its entirety with the patient.**

Physician Signature \_\_\_\_\_ Date \_\_\_\_\_



**Page II: Past Surgical History and Hospitalizations**

Please list all of the operations that you have had and any complications of anesthesia.

<u>Operation</u>	<u>Date</u>	<u>Hospital</u>	<u>Anesthesia Complications (if any)</u>

**Medications and Allergies**

List your drug allergies (if any):  No known drug allergies

<b>Drug Name</b>	<b>Allergic Reaction</b>

Have you ever been to the Emergency Room or admitted to the Hospital for medical reasons?

<u>Date</u>	<u>Hospital</u>	<u>Reason for ER Visit or Hospitalization</u>

**Page III: Family Medical History and Social History**

**Family Medical History**

<u>Relation</u>	<u>Deceased?</u>	<u>Medical Problems</u>
Mother	_____	_____
Father	_____	_____
	<u>How many?</u>	
Brothers	_____	_____
Sisters	_____	_____
Sons	_____	_____
Daughters	_____	_____
	<u>Specify Relation</u>	
Other	_____	_____
Other	_____	_____

**Social History**

What is your marital status? _____ Do you have children? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, how many? _____
Are you working now? <input type="checkbox"/> Yes <input type="checkbox"/> No What is (or was) your occupation? _____
Have you ever smoked cigarettes? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes: How many packs a day? _____ At what age did you start smoking? _____ Do you smoke now? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, at what age did you stop? _____
Approximately how many drinks of alcohol do you consume in a week? _____
Who do you live with? _____
Where were you born? _____ If outside the U.S., when did you immigrate? _____
Do you have stairs at home? <input type="checkbox"/> Yes <input type="checkbox"/> No
Have you used illicit drugs? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, which drugs and how recently? _____

**Page IV: Past Medical History**

**List of common conditions (check all that apply):**

**Heart**

- High Blood Pressure
- High Cholesterol
- Previous Heart Attack
- Congestive Heart Failure
- Atrial Fibrillation or other Arrhythmia
- Heart Murmur
- Chest Pain
- Stress Test (When? \_\_\_\_\_)
- Echocardiogram (When? \_\_\_\_\_)

**Brain and Nervous System**

- Previous Stroke or TIA
- Alzheimer's or other Dementia
- Multiple Sclerosis
- Epilepsy or Seizures
- Parkinson's Disease

**Gastrointestinal**

- GERD/Esophageal reflux/gastritis
- Stomach Ulcer
- Liver Disease
- Bleeding from stomach or colon
- Colonoscopy (When? \_\_\_\_\_)

**Dental**

- Loose Teeth

**Psychiatric / General**

- Anxiety
- Depression
- Chronic fatigue

**Lungs**

- Asthma
- Emphysema/Chronic Bronchitis/COPD
- Sleep Apnea
- Pneumonia (When? \_\_\_\_\_)
- Pulmonary Embolism
- Joints / Musculoskeletal
- Degenerative Arthritis or Osteoarthritis
- Rheumatoid Arthritis
- Lupus
- Psoriatic Arthritis
- Ankylosing Spondylitis
- Fibromyalgia
- Osteoporosis

**Endocrine**

- Diabetes
- Hypothyroid
- Recently took Prednisone

**Vascular / Heme Previous**

- Blood Clot Previous Blood
- Transfusion Anemia
- Varicose veins
- Bleeding problems
- Cancer (Specify: \_\_\_\_\_)

**Kidneys**

- Kidney Disease
- Dialysis
- Urinary Tract Infections
- BPH
- Incontinence

**Please list all other medical conditions:**

---

---

---

## Page V: Review of Systems

### General

- I get tired easily
- I have night sweats
- I have fever and/or chills
- I have recently gained weight
- I have recently lost weight
- I have a poor appetite

### Eyes

- I wear glasses or contact lenses
- I have blurry vision or changes in my vision
- I have eye pain

### Ears, Nose, Mouth & Throat

- I have ringing in my ears
- I have hearing loss
- I have frequent nosebleeds
- I have seasonal allergies
- I have nasal congestion
- I have frequent post-nasal drip
- I have bleeding gums
- I have dentures
- I have jaw pain
- I have loose teeth
- I have a hoarse voice
- I have neck pain
- I have neck stiffness
- I have swollen glands in my neck

### Respiratory

- I have a cough
- I am short of breath when resting
- I am short of breath when walking
- I have had Tuberculosis
- I have frequent wheezing

### Neurological

- I have frequent headaches
- I have seizures
- I have dizziness
- I have a tremor
- I have numbness and tingling
- I faint frequently

### Psych/Mood

- I feel depressed
- I am anxious
- I have difficulty concentrating
- I have difficulty sleeping
- I have mood swings
- I have hallucinations

### Cardiac

- I have chest pains
- I have palpitations
- I have a murmur
- I have swelling in my legs
- I can not sleep lying flat

### Gastro

- I have belly pain
- I have a mass in my belly
- I have regular heartburn
- I have trouble swallowing
- I have frequent nausea and vomiting
- I have diarrhea
- I have constipation
- I have blood in my stool
- I have a hernia

### Kidney

- I have painful urination
- I have very frequent urination
- I am incontinent of urine
- I have blood in my urine

### Musculoskeletal

- My joints are stiff
- My joints are swollen
- I have joint pain
- I recently broke a bone
- I have muscle pain

### Skin

- I have a rash

### Endocrine

- I am very thirsty and urinate frequently
- I am anxious
- I have hair loss

### Heme/Lymph

- I bruise easily
- I have had blood clots
- I have swollen glands

Additional Comments:

---

---

---

**Page VI: Patient Medical History**

<b>Patient Name:</b> _____ <b>Primary Care Provider Dr. Cardiologist/Specialist Dr.</b> _____ <b>Phone:</b> _____ <b>Diagnosis:</b> _____ <b>Surgical Procedure:</b> _____	<b>Date of Birth:</b> _____ <b>Phone:</b> _____ <b>Surgeon:</b> _____ <b>Phone:</b> _____
<b>METS Score</b> (Nurses use only): _____            Wheelchair bound? _____            Bedridden? _____	<b>Height:</b> _____ <b>Weight:</b> _____
Yes    No	Yes    No
Do you have or are you being treated for high blood pressure? If yes, how many years? _____	<input type="checkbox"/> <input type="checkbox"/>
Do you have chest pain with walking/normal activity? With Exercise?	<input type="checkbox"/> <input type="checkbox"/>
Have you ever had a coronary bypass or angioplasty?	<input type="checkbox"/> <input type="checkbox"/>
Have you ever had a heart attack? If yes, how many? _____ When? _____	<input type="checkbox"/> <input type="checkbox"/>
Do you have a heart stent? If yes, how many? _____ When? _____	<input type="checkbox"/> <input type="checkbox"/>
Do you have weak or failing heart (Congestive Heart Failure, (CHF)	<input type="checkbox"/> <input type="checkbox"/>
Do you have an irregular heartbeat or heart rhythm?	<input type="checkbox"/> <input type="checkbox"/>
Do you have a heart murmur or mitral valve prolapsed?	<input type="checkbox"/> <input type="checkbox"/>
Do you take daily medication for asthma?	<input type="checkbox"/> <input type="checkbox"/>
Do you have a history of bronchitis or emphysema (COPD)?	<input type="checkbox"/> <input type="checkbox"/>
Do you smoke? If yes, how many packs/day: _____ How many years have you been a smoker?: _____	<input type="checkbox"/> <input type="checkbox"/>
Have you had any recent colds, fever or flu symptoms?	<input type="checkbox"/> <input type="checkbox"/>
Do you have diabetes? If yes, for how many years?: _____ Complications?: _____	<input type="checkbox"/> <input type="checkbox"/>
Do you have kidney problems (other than kidney stones)?	<input type="checkbox"/> <input type="checkbox"/>
Do you have liver problems?	<input type="checkbox"/> <input type="checkbox"/>
Have you ever had a heart valve replacement or repair?	<input type="checkbox"/> <input type="checkbox"/>
Do you have a pacemaker or defibrillator?	<input type="checkbox"/> <input type="checkbox"/>
Have you ever been told that you have a widening of your aorta or that you have an aortic aneurysm?	<input type="checkbox"/> <input type="checkbox"/>
Have you ever been told that you have peripheral vascular disease?	<input type="checkbox"/> <input type="checkbox"/>
Have you ever had a stress test? If yes, Where? _____ When? _____	<input type="checkbox"/> <input type="checkbox"/>
Have you ever had a cardiac echo test? If yes, Where? _____ When? _____	<input type="checkbox"/> <input type="checkbox"/>
Have you ever had a heart catheterization? If yes, Where? _____ When? _____	<input type="checkbox"/> <input type="checkbox"/>
Do you have difficulty breathing (Do you wheeze)?	<input type="checkbox"/> <input type="checkbox"/>
Do you use supplemental oxygen?	<input type="checkbox"/> <input type="checkbox"/>
Do you have a history of sleep apnea? CPAP?	<input type="checkbox"/> <input type="checkbox"/>
Have you ever been witnessed to stop breathing while asleep?	<input type="checkbox"/> <input type="checkbox"/>
Do you take insulin?	<input type="checkbox"/> <input type="checkbox"/>
Have you ever had Hepatitis A/B/C/D? (Circle)	<input type="checkbox"/> <input type="checkbox"/>

**Page VII: Patient Medical History (Continuation)**

	Yes	No		Yes	No
Do you drink alcohol every day? If yes, how many Drinks/day: _____	<input type="checkbox"/>	<input type="checkbox"/>	Do you use recreational drugs? If yes, Specify _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you have a history of anemia?	<input type="checkbox"/>	<input type="checkbox"/>	Do you have a history of sickle cell disease or trait?	<input type="checkbox"/>	<input type="checkbox"/>
Do you take any blood thinners (e.g. Coumadin)?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Do you have history of cancer?	<input type="checkbox"/>	<input type="checkbox"/>
Do you take Aspirin or Ibuprofen regularly?	<input type="checkbox"/>	<input type="checkbox"/>	Are you on Chemo Therapy?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have seizures or take anti-seizure medications?	<input type="checkbox"/>	<input type="checkbox"/>	Do you have neuromuscular disease (including Parkinson's, ALS, Etc)?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had a stroke (CVA, mini stroke (TIA or bran attack)? If yes, when?: _____	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Do you have a brain tumor, brain aneurysm or other vascular lesion of the brain?	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Have you been told that it is difficult to place a breathing tube in your airway (intubate)?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Do you have a history of severe reaction to anesthesia?	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Do you or a family member have a history of high fever after anesthesia (malignant hyperthermia)?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Do you suffer from chronic pain?	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Do you have a history of severe nausea and vomiting after anesthesia?	<input type="checkbox"/>	<input type="checkbox"/>	Is there a possibility you could be pregnant? LMP: _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you have an autoimmune disease (such as Rheumatoid Arthritis, Sarcoidosis or Lupus)?	<input type="checkbox"/>	<input type="checkbox"/>	Do you have any other medical problems that we have not asked you about? If yes, specify: _____	<input type="checkbox"/>	<input type="checkbox"/>
Is your surgery a total joint or spine surgical procedure?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Is religion or spirituality important to you as you cope with your illness?	<input type="checkbox"/>	<input type="checkbox"/>

**OFFICE USE: EKG results good for 6 months. Chemistry lab results good for 3 months**

Please list the medications you currently take and the dose:

Medication: \_\_\_\_\_ Dose: \_\_\_\_\_

Medication: \_\_\_\_\_ Dose: \_\_\_\_\_