INTERNAL MEDICINE ASSOCIATES, S.C. - NEW PATIENT QUESTIONNAIRE

PATIENT'S NAME: **AGE:** **DATE OF EXAM:** / /

REFERRED BY: **MOST RECENT PRIMARY DOCTOR:**

PLEASE ANSWER EACH QUESTION BELOW BY CHECKING THE APPROPRIATE BOXES.

IF YOU DO NOT UNDERSTAND THE QUESTION OR IF IT DOES NOT APPLY, LEAVE YOUR RESPONSE BLANK.

DURING THE PAST 3 MONTHS OR LONGER HAVE YOU:	**YES**	**NO**	**PHYSICIAN'S NOTES**
FELT CONSTANTLY FATIQUED OR TIRED?	☐	☐	
☐ LOST OR ☐ GAINED MORE THAN 10 POUNDS?	☐	☐	
HAD TROUBLE ☐ FALLING OR ☐ STAYING ASLEEP?	☐	☐	
FELT EXTREMELY SAD OR DEPRESSED?	☐	☐	
HAVE YOU RECENTLY BEEN EXPERIENCING:	**YES**	**NO**	
☐ FREQUENT OR ☐ SEVERE HEADACHES?	☐	☐	
FREQUENT DIZZINESS OR LIGHTHEADEDNESS?	☐	☐	
☐ BLURRED OR ☐ DOUBLE VISION?	☐	☐	
☐ CONSTANT RINGING IN THE EARS OR ☐ HEARING LOSS?	☐	☐	
☐ ITCHY EYES ☐ FREQUENT SNEEZING ☐ NASAL CONGESTION?	☐	☐	
SINUS PRESSURE, DISCHARGE OR POST NASAL DRIP?	☐	☐	
☐ CHEST CONGESTION ☐ COUGH OR ☐ WHEEZING?	☐	☐	
SHORTNESS OF BREATH?	☐	☐	
CHEST PAIN, PRESSURE OR DISCOMFORT?	☐	☐	
EPISODES OF ☐ HEART RACING OR ☐ IRREGULAR BEATS?	☐	☐	
PERSISTENT SWELLING (EDEMA) OF YOUR FEET OR ANKLES?	☐	☐	
FREQUENT ☐ NAUSEA OR ☐ VOMITING?	☐	☐	
FREQUENT HEARTBURN, ACID REFLUX OR INDIGESTION?	☐	☐	
☐ A CHANGE IN BOWEL HABITS ☐ CONSTIPATION ☐ DIARRHEA?	☐	☐	
STOMACH OR ABDOMINAL PAIN?	☐	☐	
RECTAL BLEEDING ☐ ON THE TISSUE ☐ IN YOUR STOOL?	☐	☐	
DO YOU HAVING BURNING OR PAIN WHEN YOU URINATE?	☐	☐	
DO YOU GET UP MORE THAN ONCE AT NIGHT TO URINATE?	☐	☐	
ARE YOU CURRENTLY EXPERIENCING PAIN IN THE:	**YES**	**NO**	
☐ NECK ☐ SHOULDERS ☐ ARMS ☐ WRISTS ☐ HANDS?	☐	☐	
☐ LOW BACK ☐ HIPS ☐ LEGS ☐ ANKLES ☐ FEET?	☐	☐	
DO YOU HAVE CONSTANTLY PAINFUL, STIFF OR SWOLLEN JOINTS?	☐	☐	
HAVE YOU RECENTLY NOTICED A NEW SKIN RASH OR LUMP?	☐	☐	
DO YOU HAVE ANY SKIN LESIONS WHICH HAVE RECENTLY CHANGED?	☐	☐	
DO YOU EXERCISE FOR AT LEAST 20 MINUTES 3 TIMES A WEEK?	☐	☐	
DO YOU SMOKE ☐ CIGARETTES ☐ CIGARS ☐ PIPE ☐ CHEW TOBACCO	☐	☐	
AVERAGE # OF CIGARETTES/DAY: FOR YEARS.			
DID YOU SMOKE IN THE PAST? ☐ YES ☐ NO # OF YEARS: YR QUIT:			
WHAT IS YOUR AVERAGE CAFFIENE INTAKE PER DAY (CUPS OR OUNCES)?			
COFFEE: TEA: SODA:	**YES**	**NO**	
DO YOU AVERAGE MORE THAN 1 ALCOHOLIC BEVERAGE PER DAY?	☐	☐	
DO YOU HAVE A HISTORY OF ALCOHOLISM OR STREET DRUG USE?	☐	☐	
DO YOU HAVE ANY OTHER PROBLEMS YOU WISH TO DISCUSS?	☐	☐	

PLEASE TURN OVER AND COMPLETE QUESTIONS ON BACK SIDE OF QUESTIONNAIRE!!!

WOMEN ONLY: PLEASE ANSWER THE OBSTETRIC AND GYNECOLOGIC RELATED QUESTIONS BELOW:	PHYSICIAN'S NOTES:
ARE YOU STILL HAVING MENSTRUAL PERIODS? ☐ YES ☐ NO	MENARCHE MENOPAUSE
# PREGNANCIES: # MISCARRIAGES: # ABORTIONS:	LNMP ☐ REG ☐ IRREG
LAST PAP SMEAR(YEAR): LAST MAMMOGRAM:	INTERVAL: FLOW:
ARE YOU TAKING BIRTH CONTROL PILLS OR HORMONES? ☐ YES ☐ NO	DUB:
DO YOU DO MONTHLY SELF BREAST EXAM ? ☐ YES ☐ NO	
HISTORY OF ☐ PREVIOUS OR ☐ NEW BREAST LUMP? ☐ YES ☐ NO	GYNECOLOGIST:

PERSONAL MEDICAL HISTORY: If you have a history of any of the illnesses below, please check the appropriate box(es).

☐ Migraine Headaches	☐ Angina or Heart Attack	☐ Diabetes
☐ Stroke or TIA	☐ Congestive Heart Failure	☐ Thyroid Disease
☐ Seizures or Epilepsy	☐ Esophageal Reflux-GERD	☐ Gout
☐ Glaucoma	☐ Peptic Ulcer Disease	☐ Arthritis
☐ Allergies or Chronic Sinusitis	☐ Spastic Colon/Irritable Bowel	☐ Anemia
☐ Asthma	☐ Diverticulitis	☐ Phlebitis
☐ Emphysema	☐ Colon Polyps	☐ Cancer
☐ High Blood Pressure	☐ Kidney Stones	☐ Depression or Panic Attacks
☐ High Cholesterol or Lipids	☐ Recurrent Urinary Infections	☐ Sexually Transmitted Disease
☐ Other Major Illnesses Not Listed:		

PERSONAL SURGICAL HISTORY: Check those operations which you have had performed. Leave blank if uncertain.

☐ Tonsillectomy	☐ Tubal Ligation	☐ Prostate Surgery	☐ Spine Surgery
☐ Appendectomy	☐ Vasectomy	☐ Colon Surgery	☐ Orthopedic Surgery
☐ Gallbladder	☐ Hernia R L	☐ Ulcer Surgery	☐ Cancer Surgery
☐ Hysterectomy	☐ Hemorrhoidectomy	☐ Breast Biopsy R L	☐ Cataract R L
☐ Ovaries R L	☐ Bladder Repair	☐ Mastectomy R L	☐ Cosmetic Surgery
☐ Other Major Surgery Not Listed:			

FAMILY HISTORY:

Father: ☐ Living ☐ Deceased Age: Mother: ☐ Living ☐ Deceased Age: ☐ Adopted

Brothers: Number Living: Number Deceased: Sisters: Number Living: Number Deceased:

If a member of your immediate family has had any of the following illnesses, please check the appropriate box(es) below:

☐ High Blood Pressure ☐ High Cholesterol ☐ Diabetes ☐ Thyroid Disease ☐ Osteoporosis

☐ Breast Cancer ☐ Ovarian Cancer ☐ Colon Polyps ☐ Colon Cancer ☐ Prostate Cancer

Has a male family member under age 55 or a female under age 65 had a: ☐ Heart Attack? ☐ Stroke?

SOCIAL HISTORY: Please answer the following questions:

Marital Status: ☐ Single ☐ Married ☐ Re-married ☐ Separated ☐ Divorced ☐ Widowed

Occupation: ☐ Retired ☐ Disabled

Number of Children: Nationality (optional):

SECTIONS BELOW TO BE COMPLETED BY PHYSICIAN ONLY:

ALLERGIES: ☐ **None Known**

DRUG INTOLERANCE:

CURRENT MEDICATIONS:

IMMUNIZATION: Td: Pneumovax: Hep B: Hep A: Annual Flu: