

USF New Adult Patient Questionnaire (Internal Medicine)

Name: _____ Age: _____ Sex: M F Today's Date: _____

Previous Primary Care Doctor (name & phone #): _____

Other doctors treating you (name, specialty, phone #): _____

Current Medical Problems/Diagnoses:

Past Medical Problems: (circle all that apply)

High blood pressure	Heart attack	Heart failure	Abnormal heart valves
High cholesterol	Diabetes	Thyroid disease	Osteoporosis (thin bones)
Kidney failure/disease	Kidney stones	Enlarged prostate	Blood in urine
Urinary incontinence	Irregular menses	Miscarriages	Infertility
Blood clots (legs/lungs)	Anemia	Blood transfusion (list date) _____	
Arthritis	Gout	Broken bone (list location(s)) _____	
Tuberculosis	COPD (lung dz)	Asthma	Ever intubated (tube in lungs)
Hepatitis	Gallstones	Stomach ulcers	Stomach/Intestinal bleeding
Irritable Bowel disease	Colitis	Pancreatitis	Obesity
Seizures	Strokes	Migraine headaches	Glaucoma
Depression/Anxiety	Eating disorder	Other psychiatric disorders: _____	
Sleep apnea/sleep disorder	Anesthesia allergy	Food allergy	Eczema

Cancer: list type(s) _____

Other problems not listed: _____

For Women only: List dates of:

Last menstrual period: _____ Menopause symptoms: _____ Hormone therapy: _____
Pregnancies: _____ Deliveries: _____ Miscarriages: _____

Past Surgeries: (include dates)

Current Medications & Doses: (include inhalers, birth control & over-the-counter medicines)

1. _____ 2. _____ 3. _____
4. _____ 5. _____ 6. _____
7. _____ 8. _____ 9. _____
10. _____ 11. _____ 12. _____

Medication Allergies:

Name: _____	Reaction _____	Age/Date _____
Name: _____	Reaction _____	Age/Date _____
Name: _____	Reaction _____	Age/Date _____

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Social History:

Place of Birth: _____ Level of Education: _____ Occupation: _____
Travel outside USA?: _____ Frequency of exercise/week: _____
Hobbies: _____ Guns/weapons in the home: _____
Who lives with you currently: (spouse, children, parents, pets?) _____

Smoking history: Never used tobacco _____ Age Started _____ Age Stopped _____ Packs per day _____
Alcohol intake: Never _____ How often? _____ Number of drinks per occasion _____
Drug Use (marijuana, street drugs, IV): Never _____ Which drug? _____ Frequency _____

History of Sexually Transmitted Infections:(type/when?) _____
Sexually Active?: (with men, women or both?) _____
Abused by others in the past or currently (who/when?): _____

Family History (blood relatives): If known, list current age or age at death & major health problems

Mother: _____
Father: _____
Brothers/Sisters: _____
Children: _____
Your Aunts/Uncles: _____
Your Grandparents: _____

Health Screening/Maintenance: (Date)

Last Complete Physical Exam: _____ Last hospitalization: _____
Last Colonoscopy: _____ Last Stool Cards: _____ Last Prostate exam/test: _____
Last Pelvic/Pap smear: _____ Last Mammogram: _____ Last Bone Density Test: _____
Last Cholesterol test: _____ Last EKG (heart tracing): _____ Last Stress Test: _____
Last Tetanus shot: _____ Last Influenza shot: _____ Last Pneumonia shot: _____
Last Eye appointment: _____ Last Podiatry appt. (feet): _____ Last Dental Appt.: _____

In Emergency, Contact Who?:

Name: _____ Relationship to you: _____ Phone Number: _____

Name of your Health Care Proxy: _____ Relationship to you: _____

Do you have a Living Will? Yes or No