General Internal Medicine Clinic
New Patient Questionnaire

Date: _____ Name: _____

What would you like to be called by the doctor? _____

Marital Status: _____

Please list how you would like to be contacted, for test results: _____

In case of emergency, contact: _____

Phone: _____ Relationship: _____

Allergies or Drug Reactions (list drug and reaction):

Please list your main reason for making an appointment:

Please list your current medical problems: (list the conditions you are currently being treated for)

Please list other doctors who are also currently treating you:

Past medical history: Please list all hospitalizations, major illnesses and surgeries:

Who lives with you in your home? (spouse, children, in-laws, significant others, etc.)

Your Occupation: _____

What are your hobbies? _____

Birthplace: _____ Education:_____

Have you recently traveled outside of Florida? (If so, where?):

Do you get regular exercise: (describe):

Do you wear seat belts? Always Usually Occasionally Never

Smoking history: Check which one applies:

_____Never smoked

_____Previous smoker Started (age) _____ Stopped (age) _____On average, how many packs per day? _____

_____Current smoker: Started (age) _____ On average, how many packs per day?

Do you drink wine, beer, or other alcoholic beverages? _____ If yes, how many times in the last year have you drank 4 or more drinks on one occasion?_____

Have you ever had a drinking problem? _____

How many cups of coffee or caffeinated drinks do you drink daily? _____

Do you use marijuana, cocaine, any street drugs or prescription drugs not prescribed for you? Yes No (Leave blank if you would rather discuss with doctor.)

Family History:

	Age if living	**Age at death**	**Health problems or cause of death**
Mother			
Father			
(Brothers and Sisters):			
Children:			

*Please include cancer, diabetes, heart attacks, high blood pressure, strokes, tuberculosis, and other important illnesses.

Name of Medication	Prescribed By	Dosage	When is the Medication Taken	Purpose	Refills needed
		mg/ units/ puffs/ drops	How many times per day? Morning and/or night? After meals?		
Medication ABC	*Dr. ABC*	*5 mg*	*2 times, morning and night*	*Ulcer*	*yes*

Please list all the medications you are taking, including over-the-counter medications, vitamins, herbs, and other treatments. Include the name of the doctor who prescribed the medications, and why you are taking the medications (e.g. for high blood pressure, arthritis, cholesterol, etc.) If you are not sure why you are taking the medication, write "don't know", and ask your doctor to explain why and how to use the drug properly. Also ask about the drug's side effects and what to do if you experience a side effect.

Remember to update your medicine list when your doctor stops, changes, or updates your medications. Please bring your medication list with you to doctors' visits, emergency room or walk in clinic visits, nursing home visits, to your home health providers, and to the hospital. If you are unable to bring a medication list with you to your doctor's appointment, please bring your bottles.

Past medical history: Please check whether you have ever had the following:

	Yes	No
Hypertension		
Diabetes		
Cancer		
Heart murmur		
Heart problems		
Asthma		
Emphysema or COPD		
Positive skin test for TB		
Tuberculosis		
Blood clots		
Asbestos exposure		
Ulcers		
Colon polyps		
Gall bladder problems		
Hepatitis or jaundice		
Liver problems		

	Yes	No
Pancreatitis		
Kidney problems		
Abnormal pap smear in past		
High PSA (men only)		
Seizure		
Depression or anxiety		
Stroke		
Blood problems		
Thyroid problems		
Arthritis		
Radiation treatments to head or neck		
Previous herpes, gonorrhea, syphilis, or chlamydia		
HIV infection		
Other (list)		

Check if you've had	VACCINATIONS:	Date OF LAST ONE
	Tetanus	
	Influenza (FLU shot)	
	Influenza (H1N1)	
	Pneumonia	
	Hepatitis A	
	Hepatitis B	
	Shingles	
	Other (list)	

Check if you've had	TESTS	DATE of Last:
	Stool cards for colon cancer testing:	
	Colonoscopy	
	Sigmoidoscopy	
	Bone density	
	Mammogram	
	Pap smear (women only)	
	PSA (men only)	
	Eye exam by eye doctor	

Please check whether or not you currently have (or had them in the past few weeks) these conditions:

	YES	NO
Fatigue		
Fever or chills		
Recent weight change		
Headache		
Vision problems		
Double vision		
Blurred vision		
Eye itching		
Eye pain		
Hearing loss		
Ear ache		
Ringing in ears		
Runny nose		
Nose bleeds		
Nasal congestion		
Snoring		
Hoarseness		
Sore throat		
Mouth sores		
Breast lump or pain		
Chest pain		
Irregular heart beat		
Pounding heart beat		
Shortness of breath		
Cough		
Wheezing		
Decreased appetite		
Increased appetite		
Difficulty swallowing		
Heartburn		
Nausea		
Vomiting		
Abdominal pain		

	YES	NO
Black tarry stools		
Rectal bleeding		
Diarrhea		
Constipation		
Blood in urine		
Urinating too often		
Too much urine		
Getting up at night to urinate		
Pain with urination		
Excessive thirst		
Weakness		
Easy bruising		
Muscle aches		
Joint pain		
Joint stiffness		
Swelling in arms or legs		
Dizziness		
Fainting		
Memory problems		
Numbness		
Anxiety		
Depression		
Trouble sleeping		
Hallucinations		
Dry skin		
itching		
Lump or spot on skin		
Rash		
Stress		

Men only:

	YES	NO
Straining with urination		
Pain or lump on testicle		
Discharge from penis		
Prostate problems		
Difficulty with erection		
Sexual difficulties		

Women only:
Date of last menstrual period:_____

	YES	NO
Pelvic pain		
Abnormal vaginal bleeding		
Vaginal discharge		
Sexual difficulties		

Geriatric Intake—please complete if you are over 65 years old, or if you have concerns about the the topics listed below.

Do you have medical Durable Power of Attorney for Healthcare?
[ ] No [ ] Yes (if yes, please bring a copy) Name/Relationship_____

Do you have a living will? [ ] No [ ] Yes (If yes, please bring a copy)

We want to know **if you need help** with any of the following and **who helps you**.

Task	Don't need help	Need help	Who helps
Feeding yourself			
Getting from bed to a chair			
Getting to the toilet			
Getting dressed			
Bathing			
Using the telephone			
Taking your medicines			
Preparing your meals			
Managing money/finances/checkbook			
Doing laundry			
Doing housework			
Shopping for groceries			
Driving			
Doing handyman work			
Climbing a flight of stairs			
Getting places beyond walking distance			

Are you afraid of falling? [ ] Yes [ ] No
Have you had a fall in the past year? [ ] Yes [ ] No
If yes, please tell us about your last fall:
Date:_____
How did this fall happen:_____
Did you need to see a doctor or other professional for treatment after this fall: [ ]Yes[] No

Do you use a walking aid such as a cane or walker (circle one) [ ] Yes [ ] No

Do you drive? [ ] Yes [ ] No