USF New Adult Patient Questionnaire (Internal Medicine)

Name: Age: Sex: Female Today's Date:

Previous Primary Care Doctor

Name: Phone#:

Other Doctors Treating You

Name: Specialty: Phone#:
Name: Specialty: Phone#:
Name: Specialty: Phone#:

Current Medical Problems/Diagnoses:

Past Medical Problems: (place a check mark next to all that apply)

- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Kidney failure/disease
- ☐ Urinary incontinence
- ☐ Blood clots (legs/lungs)
- ☐ Arthritis
- ☐ Tuberculosis
- ☐ Hepatitis
- ☐ Irritable Bowel disease
- ☐ Seizures
- ☐ Depression/Anxiety
- ☐ Blood transfusion (list date)
- ☐ Broken bone - Location(s)
- ☐ Cancer: list type(s)
- ☐ Other problems not listed:
- ☐ Sleep apnea/sleep disorder
- ☐ Heart attack
- ☐ Diabetes
- ☐ Kidney stones
- ☐ Irregular menses
- ☐ Anemia
- ☐ Gout
- ☐ COPD (lung disease)
- ☐ Gallstones
- ☐ Colitis
- ☐ Strokes
- ☐ Eating Disorder
- ☐ Anesthesia allergy
- ☐ Heart failure
- ☐ Thyroid disease
- ☐ Enlarged prostate
- ☐ Miscarriages
- ☐ Asthma
- ☐ Stomach ulcers
- ☐ Pancreatitis
- ☐ Migraine headaches
- ☐ Food allergy
- ☐ Abnormal heart valves
- ☐ Osteoporosis (thin bones)
- ☐ Blood in urine
- ☐ Infertility
- ☐ Ever intubated (tube in lungs)
- ☐ Stomach/Intestinal bleeding
- ☐ Obesity
- ☐ Glaucoma
- ☐ Eczema
- ☐ Other psychiatric disorders

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

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

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?)

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

Medication Allergies:

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

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)?

Health Screen/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 appts:	Last Podiatry appt. (feet):	Last Dental Appt:

In Emergency, Contact Who?:

Name:	Relationship to you:	Phone Number

Name of your Health Care Proxy:

Do you have a living will: