New Patient Health Questionnaire

PATIENT NAME_____
Date of birth: _____ **Age:** _____

Reason for today's visit:

_____
_____
_____

Current Medications, Vitamins, Herbal Supplements:

_____
_____
_____
_____
_____

Past Medical History: List medical problems for which you have been diagnosed or treated, or continue to receive medications:

_____
_____
_____
_____
_____

Allergies to Medications or Latex & Type of Reaction**:**

_____
_____
_____

Family Medical History: (write in which family members)

- ☐ Diabetes _____
- ☐ High Cholesterol _____
- ☐ Obesity _____
- ☐ High Blood Pressure _____
- ☐ Heart Disease _____
- ☐ Osteoporosis _____
- ☐ Calcium problems _____
- ☐ Thyroid _____
- ☐ Adrenal/Pituitary Problems _____
- ☐ Cancer (specify type) _____
- ☐ Other (please describe _____

_____
_____

List Hospitalizations or Surgeries – what year?

_____
_____
_____

Social History:
Occupation:_____ #_____hours/week
Smoking? ☐ No ☐ Yes #_____pack(s) per day?
Age when smoking began_____
Alcohol? ☐ No ☐ Yes #_____drinks per day/week/month
Drug Use? ☐ No ☐ Yes Type: _____
Exercise? ☐ No ☐ Yes #_____ days per week
Relationship status:
☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

SYMPTOM REVIEW: ***[As always, we recommend that you also discuss these symptoms with your primary care doctor]***

Please select recent or current symptoms:

General:
☐ fatigue ☐ fever ☐ general weakness ☐ weight gain ☐ weight loss

HEENT:
☐ eyesight problems ☐ trouble swallowing ☐ hoarseness ☐ headaches

Heart/Lung:
☐ chest pain ☐ palpitations ☐ shortness of breath ☐ cough

Gastrointestinal:
☐ abdominal pain ☐ nausea ☐ vomiting ☐ diarrhea ☐ constipation

Genitourinary:
☐ difficulty urinating ☐ pain urinating ☐ menstrual irregularity ☐ erectile dysfunction

Neurologic:
☐ numbness ☐ tingling ☐ weakness ☐ tremors

Endocrine:
☐ cold intolerance ☐ heat intolerance

Muscle/Bones:
☐ joint pain ☐ broken bones

Psychiatric:
☐ depression ☐ anxiety ☐ other

Hematologic:
☐ bruising ☐ bleeding

Skin:
☐ dry skin ☐ rash ☐ acne

FOR DIABETIC PATIENTS ONLY
If you do not have diabetes, you may skip this section

How long have you had diabetes? _____
Have you ever been hospitalized for your diabetes? ☐ yes ☐ no
How many times a day do you check your finger stick glucose? _____

Please provide your blood sugar (BS) during the following times of day					
Time of day	**Fasting AM**	**Before Lunch**	**Before Dinner**	**Bedtime**	**Other**
Average BS					
Highest BS					

Have you ever needed help from another person to recover from a low blood sugar? ☐ yes ☐ no
Do you have a Glucagon emergency kit? ☐ yes ☐ no
Do you have numbness, tingling or pain in your feet or legs? ☐yes ☐no
Have you had a flu shot this year? ☐yes ☐no
If so, when: _____
Have you ever had a vaccination for pneumonia? ☐yes ☐no
If so, when: _____
When was the last time you saw an eye doctor for a diabetes eye exam?
_____
Who is your eye doctor?_____

Have you ever been told you have bleeding or diabetic changes in your eyes? ☐yes ☐no

Have you ever had a heart attack or been told you have coronary disease? ☐yes ☐no

Do you take a daily Aspirin (either full dose or baby dose)? ☐yes ☐no