

New Patient Questionnaire

Today's Date:

What is the reason for your visit today?		
Demographics		
Name:		Date of Birth:
Cell: ()	Home: ()	Work: ()
Email Address:		
Occupation (if retired, list prev. occup.):		Employer:
Date last worked:		Marital Status:
Language:		
Race <i>(select all that apply)</i> : <input type="checkbox"/> White <input type="checkbox"/> Black or African American <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> Unknown <input type="checkbox"/> Decline to Answer		
Ethnicity <i>(select one)</i> : <input type="checkbox"/> Not Hispanic or Latino/a <input type="checkbox"/> Hispanic or Latino/a <input type="checkbox"/> Unknown <input type="checkbox"/> Decline to answer		
Personal Environment		
Support Systems: <input type="checkbox"/> Lives w/spouse, signif other, family or friends <input type="checkbox"/> Lives alone <input type="checkbox"/> Lives in own house <input type="checkbox"/> Lives in nursing home <input type="checkbox"/> Lives in assisted living facility <input type="checkbox"/> Incarcerated <input type="checkbox"/> Homeless <input type="checkbox"/> Transportation problems exist and will require assistance <input type="checkbox"/> Other support system issues:		
Home Health Care agency/Nursing Home? (If applicable)		
Phone:		
Pharmacy Name:		
Location:		Phone:
Physician Information		
Referring Physician:		
City/State:		Phone:
Primary Care Physician:		
City/State:		Phone:
Other Health Care Providers:		
Radiology History & Allergies		
Have you had previous scans? Include when and where:		
CT:	Date:	Facility:
MRI:	Date:	Facility:
PET:	Date:	Facility:
Other:	Date:	Facility:
Have you ever had an allergic reaction to IV dye?		
If yes, was treatment required?		

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Drug Allergy	Type of Reaction (Example: Hives)

Allergic to: Latex Tape Iodine Barium IV Contrast (dye)

Please list all prescriptions and over-the-counter medications that you take, including vitamins and herbs.

Medication/Vitamins/Herbs	Dose	Approx Start Date	Directions/Frequency (i.e. daily, twice daily, etc.)

Activity Level and Nutrition ("X" one of the levels below)

- (0) Fully active, able to carry on all activities without restriction.
 - (1) No physically strenuous activity, but ambulatory and able to carry out light or sedentary work (e.g. office work, light housework).
 - (2) Ambulatory/capable of self-care, unable to perform any work activities. Up and about more than 50% of waking hours.
 - (3) Capable of only limited self-care, confined to bed or chair more than 50% of waking hours.
 - (4) Completely disabled and totally confined to bed or chair. Cannot carry on any self-care.
- Activities: Sedentary Daily Activities Occasional Exercise Light Exercise
 Regular Exercise Extensive Exercise
- Nutrition: Regular Meals Nutritional Supplements Liquid Diet Other:

Review of Systems ("X" if you have experienced recent symptoms below)

- Have you ever received Chemotherapy before?
 Dates: _____
 Facility: _____
- Have you ever received Radiation Therapy before?
 Dates: _____
 Facility: _____

Comments: _____

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Review of Systems Continued ("X" if you have experienced <i>recent</i> symptoms below)	
General	Eyes
<input type="checkbox"/> Fever	<input type="checkbox"/> Blurred or Double vision
<input type="checkbox"/> Chills	<input type="checkbox"/> Burning or Redness
<input type="checkbox"/> Night Sweats	<input type="checkbox"/> Discharge
<input type="checkbox"/> Weight Loss	<input type="checkbox"/> Night blindness
<input type="checkbox"/> Weight Gain	<input type="checkbox"/> Visual Difficulties
<input type="checkbox"/> Sleep disturbances	<input type="checkbox"/> Light Sensitivity
<input type="checkbox"/> Fatigue	ENMT
<input type="checkbox"/> Other:	<input type="checkbox"/> Ear Pain
Endocrine	<input type="checkbox"/> Nose bleeds
<input type="checkbox"/> Hot Flashes	<input type="checkbox"/> Sore Throat/Problems Swallowing
<input type="checkbox"/> Menstrual Irregularities	<input type="checkbox"/> Problems Hearing
<input type="checkbox"/> Other:	<input type="checkbox"/> Mouth Dryness
Hematologic/Lymphatic	<input type="checkbox"/> Bleeding Mouth or Gums
<input type="checkbox"/> Easy Bruising	<input type="checkbox"/> Ear Infections
<input type="checkbox"/> Tender or Enlarged Lymph Nodes	<input type="checkbox"/> Sinus Infections
<input type="checkbox"/> Blood Clots	<input type="checkbox"/> Altered Taste
Breast	<input type="checkbox"/> Ringing in Ears
<input type="checkbox"/> Breast Pain	Gastrointestinal
<input type="checkbox"/> Breast Mass/Lump	<input type="checkbox"/> Abdominal Pain
<input type="checkbox"/> Nipple Discharge	<input type="checkbox"/> Change in Bowel Habits
<input type="checkbox"/> Nipple Inversion	<input type="checkbox"/> Constipation
<input type="checkbox"/> Other:	<input type="checkbox"/> Diarrhea
Respiratory	<input type="checkbox"/> Heartburn
<input type="checkbox"/> Cough	<input type="checkbox"/> Nausea
<input type="checkbox"/> Shortness of Breath	<input type="checkbox"/> Vomiting
<input type="checkbox"/> Cough with sputum	<input type="checkbox"/> Black Stools
<input type="checkbox"/> Cough with blood	<input type="checkbox"/> Abdominal cramping
<input type="checkbox"/> Chest Pain	Musculoskeletal
<input type="checkbox"/> Wheezing	<input type="checkbox"/> Bone Pain/Where:
<input type="checkbox"/> Use Oxygen? Flow Rate:	<input type="checkbox"/> Muscle Pain/Where
Cardiovascular	<input type="checkbox"/> Joint Pain/Where:
<input type="checkbox"/> Irregular Heart Rate	<input type="checkbox"/> Weakness/Where:
<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Abnormal swelling/Where:
<input type="checkbox"/> Abnormal Swelling	<input type="checkbox"/> Other:
<input type="checkbox"/> Dizziness with Position Changes	Skin
<input type="checkbox"/> Palpitations	<input type="checkbox"/> Hair Loss
<input type="checkbox"/> Other:	<input type="checkbox"/> Rash/Where:
Genitourinary	<input type="checkbox"/> Skin Lesions/Where:
<input type="checkbox"/> Painful Urination	Neurologic
<input type="checkbox"/> Incontinence	<input type="checkbox"/> Dizziness
<input type="checkbox"/> Lumps/Masses	<input type="checkbox"/> Headaches
<input type="checkbox"/> Vaginal Discharge/Abnormal Bleeding	<input type="checkbox"/> Disorientation
<input type="checkbox"/> Urine Changes	<input type="checkbox"/> Numbness/Tingling-Where:
Emotion/Mood	<input type="checkbox"/> Seizures
<input type="checkbox"/> Depression	<input type="checkbox"/> Nerve Pain/Where:

<input type="checkbox"/> Anxiety	<input type="checkbox"/> Memory Loss		
<input type="checkbox"/> Other:	<input type="checkbox"/> Other:		
Medical Conditions/Diagnoses ("X" if you have ever experienced)			
<input type="checkbox"/> Cancer/Type:	<input type="checkbox"/> COPD	<input type="checkbox"/> GERD	<input type="checkbox"/> Migraines
	<input type="checkbox"/> Chronic Pain	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> MRSA
	<input type="checkbox"/> Cold Sores	<input type="checkbox"/> Hematology Disorder	<input type="checkbox"/> Multiple Sclerosis
<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Congestive Heart Failure	<input type="checkbox"/> Hepatitis/Type:	<input type="checkbox"/> Obesity
<input type="checkbox"/> Alzheimer's Disease	<input type="checkbox"/> Coronary Artery Disease	<input type="checkbox"/> HIV	<input type="checkbox"/> Osteoporosis
<input type="checkbox"/> Anxiety	<input type="checkbox"/> Dementia	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Parkinson's
<input type="checkbox"/> Arthritis/Type:	<input type="checkbox"/> Depression	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Peripheral Neuropathy
<input type="checkbox"/> Asthma	<input type="checkbox"/> Diabetes/Type:	<input type="checkbox"/> High thyroid	<input type="checkbox"/> Peripheral Vascular Disease
<input type="checkbox"/> Atrial Fibrillation	<input type="checkbox"/> Diverticulitis	<input type="checkbox"/> Low thyroid	<input type="checkbox"/> Seizure
<input type="checkbox"/> Benign Prostatic Hypertrophy	<input type="checkbox"/> Fibromyalgia	<input type="checkbox"/> Kidney Stones	<input type="checkbox"/> Stroke
<input type="checkbox"/>	<input type="checkbox"/> Frequent Headaches	<input type="checkbox"/> Mental Illness	<input type="checkbox"/> Tuberculosis
Please list below any medical conditions not marked above:			
Surgery History (Indicate Surgery Date and Facility)			
<input type="checkbox"/> AICD Placement	<input type="checkbox"/> Mastectomy		
<input type="checkbox"/> Appendectomy	<input type="checkbox"/> Orchiectomy		
<input type="checkbox"/> Bone Marrow Biopsy	<input type="checkbox"/> Orthopaedic Surgery		
<input type="checkbox"/> Breast Implants	<input type="checkbox"/> Pacemaker Placement		
<input type="checkbox"/> Breast Reduction Surgery	<input type="checkbox"/> Paracentesis		
<input type="checkbox"/> Caesarean Section	<input type="checkbox"/> Radiation Therapy		
<input type="checkbox"/> Gall Bladder Removal	<input type="checkbox"/> Splenectomy		
<input type="checkbox"/> Colposcopy	<input type="checkbox"/> Thoracentesis		
<input type="checkbox"/> Coronary Artery Bypass	<input type="checkbox"/> Thyroidectomy		
<input type="checkbox"/> Hernia Repair	<input type="checkbox"/> Tubal Ligation		
<input type="checkbox"/> Lumbar Puncture	<input type="checkbox"/> TURP		
<input type="checkbox"/> Lumpectomy	<input type="checkbox"/> Vasectomy		
<input type="checkbox"/> Mammoplasty	<input type="checkbox"/>		
Other Surgeries/Procedures:			
Have you had a Colonoscopy?	Date:	Where?	

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For Men Only	
Date of last testicular exam:	Do you perform testicular self-exams:
Date of last prostate exam:	
Have you ever had a PSA drawn:	If yes was it normal:
Comments:	
For Women Only	
Number of pregnancies:	Age at first menses:
Number of children:	Last Menstrual Period:
Age at first birth:	Menstrual Cycle Length:
# of Interrupted pregnancies:	Menopause status: <input type="checkbox"/> Pre <input type="checkbox"/> Peri <input type="checkbox"/> Post <input type="checkbox"/> Unknown
Hormone Use History: <input type="checkbox"/> Any Hormone Use <input type="checkbox"/> Contraceptive Hormone Use _____ # Years Used <input type="checkbox"/> Post-menopause Use _____ # Years Used <input type="checkbox"/> Other Hormone Use _____ # Years Used	Age at menopause: Reason for Menopause <input type="checkbox"/> Natural <input type="checkbox"/> Chemotherapy <input type="checkbox"/> Ovaries Removed <input type="checkbox"/> Other:
Did you ever breast feed?	Do you do breast self-exams?
Date of last PAP Smear:	Date of last Mammogram:
Additional History	
Smoking Status <input type="checkbox"/> Yes- current every day smoker <input type="checkbox"/> Yes- current some day smoker <input type="checkbox"/> Yes- smoker <input type="checkbox"/> Yes- but quit <input type="checkbox"/> Never	Smoking History # of Years: _____ # of Packs/Day: _____ # of Years Quit: _____
Products <input type="checkbox"/> Cigarettes <input type="checkbox"/> Chewing Tobacco <input type="checkbox"/> Pipe <input type="checkbox"/> Recreational Drug Use:	<input type="checkbox"/> Cigars <input type="checkbox"/> e-Cigarettes <input type="checkbox"/> Snuff <input type="checkbox"/> Illicit Drug Use:
Alcohol Consumption <input type="checkbox"/> Yes- current every day drinker <input type="checkbox"/> Yes- current occasional drinker <input type="checkbox"/> Yes- active <input type="checkbox"/> Yes- but quit <input type="checkbox"/> Never	Alcohol History # Days/Week: _____ # Drinks/Day: _____ # Years Quit: _____
Hazardous Materials <input type="checkbox"/> Asbestos <input type="checkbox"/> Lead <input type="checkbox"/> Radon <input type="checkbox"/> Other Hazardous Exposure:	<input type="checkbox"/> Benzene <input type="checkbox"/> Radiation <input type="checkbox"/> Other Petroleum Products:

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Family History					
RELATIONSHIP	IF LIVING			IF DECEASED	
	M/F Gender	AGE	HEALTH Good or living with illness	AGE AT DEATH	CAUSE OF DEATH
Father					
Mother					
Sibling					
Sibling					
Sibling					
Sibling					
Sibling					
Sibling					
Sibling					
Sibling					
Sibling					
Father's Father					
Father's Mother					
Mother's Father					
Mother's Mother					
Spouse					
Child					
Child					
Child					
Child					
Child					
Child					
Child					

Additional Comments:

Person completing this form (please print)

Relationship to patient

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