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**New Patient Questionnaire**

Name: \_\_\_\_\_ Age: \_\_\_\_\_

Street Address \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Telephone: \_\_\_\_\_ Cell: \_\_\_\_\_ E-mail: \_\_\_\_\_

**Present Illness:**

Why are you seeing the Doctor today: \_\_\_\_\_

How long have you had these symptoms: \_\_\_\_\_

Name of Doctor that referred you today? \_\_\_\_\_

City: \_\_\_\_\_

Name of Primary Care MD \_\_\_\_\_





**PAST MEDICAL HISTORY (please list any hospitalizations below)**

Purpose \_\_\_\_\_ Date \_\_\_\_\_  
Purpose \_\_\_\_\_ Date \_\_\_\_\_  
Purpose \_\_\_\_\_ Date \_\_\_\_\_

If female, have you ever had a mammogram?  
If yes, please state most recent date and result \_\_\_\_\_

Is there a family history of breast cancer in your family? Yes \_\_\_ No \_\_\_  
If yes, what is their relationship to you? \_\_\_\_\_

History of clotting legs, lungs, gums? \_\_\_\_\_  
Family history of clots/bleeding disorders? \_\_\_\_\_

**Is there any other history not noted above which the doctor should be aware of?**  
If yes, please explain \_\_\_\_\_

**ILLNESS AND MEDICAL PROBLEMS**

Dizzy Spells	Yes	No	Bleed Easily	Yes	No
Glaucoma	Yes	No	Bruise Easily	Yes	No
Other Eye Problems	Yes	No	Bleeding Disorder	Yes	No
Ear Trouble	Yes	No	Anemia	Yes	No
Sinus Trouble	Yes	No	Heart Attack	Yes	No
Deafness or decreased hearing	Yes	No	Heart Murmur	Yes	No
Repeated Nose Bleeds	Yes	No	Ankles Swell	Yes	No
Chronic Nose Obstruction	Yes	No	Other Heart Condition	Yes	No
Swelling in Neck	Yes	No	Stomach/Duodenal Ulcer	Yes	No
Asthma	Yes	No	Colitis	Yes	No
Bronchitis	Yes	No	Diverticulosis	Yes	No
Emphysema	Yes	No	Other Bowel Problems	Yes	No
Pneumonia	Yes	No	Hepatitis	Yes	No
Tuberculosis	Yes	No	Mononucleosis	Yes	No
Other Lung Problems	Yes	No	Gall Bladder Problems	Yes	No
Low Blood Pressure	Yes	No	Stroke	Yes	No
High Blood Pressure	Yes	No	Convulsion / Seizures	Yes	No
Scarlet Fever	Yes	No	Arthritis	Yes	No
Trouble with Anesthesia	Yes	No	Cancer Yr.	Yes	No
Diabetes	Yes	No	Have you ever received a blood transfusion?	Yes	No
Other	Yes	No	Have you ever received blood products?	Yes	No
Other			Kidney Problems	Yes	No



**WOMEN ONLY**

Heavy menstrual bleeding	Yes	No	Discharge from Nipples	Yes	No
Tender Breasts	Yes	No	Fibrocystic Disease	Yes	No
Lump or recent change in size	Yes	No	Previous Mammogram Year: _____	Yes	No
Menstrual Problems	Yes	No	Were your children breast fed?	Yes	No
Birth Control Pills	Yes	No	Do you have breast implants?	Yes	No
Number of Pregnancies	# _____		Other implants?	Yes	No
Number of Live Births	# _____		Multiple Miscarriages	Yes	No
Bra Size	_____				

**FAMILY HISTORY**

Tuberculosis	Yes	No	Diabetes	Yes	No
Asthma	Yes	No	Rheumatoid Arthritis	Yes	No
Glaucoma	Yes	No	Heart Disease	Yes	No
Cancer	Yes	No	High Blood Pressure	Yes	No
Relation:	Type of Cancer		Low Blood Pressure	Yes	No
Relation:	Type of Cancer		Blood Disorders (i.e. Sickle Cell anemia, etc.)	Yes	No
Other	Yes	No	Bleeding Tendency	Yes	No

Right-handed \_\_\_\_\_ Left-handed \_\_\_\_\_ Is this work related? \_\_\_\_\_

Date of injury: \_\_\_\_\_ Place of injury: \_\_\_\_\_

Please describe problem: \_\_\_\_\_

\_\_\_\_\_

Side affected: \_\_\_\_\_ Left \_\_\_\_\_ Right \_\_\_\_\_ Both

List previous treatment for this problem: \_\_\_\_\_

Occupation: \_\_\_\_\_ Place of Employment \_\_\_\_\_

**This information is correct and true to the best of my knowledge.**

\_\_\_\_\_  
**Patient**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Parent/Guardian**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Physician**

\_\_\_\_\_  
**Date**