

NEW PATIENT HEALTH QUESTIONNAIRE

This information will help facilitate your initial office visit so that we may focus our time on addressing your specific health concerns. This is a confidential record and information given here will not be given out without your permission.

PATIENT NAME: _____

HEIGHT _____ WEIGHT _____ GENDER _____ DATE OF BIRTH _____

REASON FOR TODAY'S VISIT: _____

REVIEW OF SYSTEMS

Please check, if you have a **PERSONAL HISTORY** for the following:

- | | | | |
|---|---|--|--|
| GENERAL
<input type="checkbox"/> Sudden weight loss
<input type="checkbox"/> Sudden weight gain
<input type="checkbox"/> Fevers, chills, sweats
<input type="checkbox"/> Constipation
<input type="checkbox"/> Fatigue
<input type="checkbox"/> Night sweats
ENDOCRINE
<input type="checkbox"/> Excessive thirst
<input type="checkbox"/> Intolerance to heat
<input type="checkbox"/> Excessive urine
<input type="checkbox"/> Hair loss
GENITO-URINARY
<input type="checkbox"/> Blood in urine
<input type="checkbox"/> Incontinence
<input type="checkbox"/> Frequent urination
<input type="checkbox"/> Painful urination
NEUROLOGICAL
<input type="checkbox"/> Loss of balance
<input type="checkbox"/> Seizures
<input type="checkbox"/> Loss of strength
<input type="checkbox"/> Tingling
<input type="checkbox"/> Weakness | HEAD AND NECK
<input type="checkbox"/> Blurred vision
<input type="checkbox"/> Eye pain
<input type="checkbox"/> Eye discharge
<input type="checkbox"/> Nosebleeds
<input type="checkbox"/> Sinus problems
<input type="checkbox"/> Loss of hearing
<input type="checkbox"/> Headaches
<input type="checkbox"/> Dentures
<input type="checkbox"/> Difficulty swallowing
<input type="checkbox"/> Other
GASTROINTESTINAL
<input type="checkbox"/> Diarrhea
<input type="checkbox"/> Blood in stool
<input type="checkbox"/> Abdominal Pain
<input type="checkbox"/> Nausea
<input type="checkbox"/> Vomiting
<input type="checkbox"/> Gas
<input type="checkbox"/> Bloating
<input type="checkbox"/> Heartburn
<input type="checkbox"/> Black, tarry smelly stools | CARDIOVASCULAR
<input type="checkbox"/> Chest pain
<input type="checkbox"/> Leg pain when walking
<input type="checkbox"/> Swelling of legs/ankles
<input type="checkbox"/> Irregular heart beat
<input type="checkbox"/> Shortness of breath when lying down
<input type="checkbox"/> Other
MUSCULOSKELETAL
<input type="checkbox"/> Joint pain
<input type="checkbox"/> Joint swelling
<input type="checkbox"/> Back pain
<input type="checkbox"/> Other
SKIN
<input type="checkbox"/> Hives
<input type="checkbox"/> Itching
<input type="checkbox"/> Change in moles
<input type="checkbox"/> Rash
PSYCHIATRIC
<input type="checkbox"/> Anxiety
<input type="checkbox"/> Depression
<input type="checkbox"/> Psychosis | BREAST
<input type="checkbox"/> Lumps
<input type="checkbox"/> Nipple discharge
<input type="checkbox"/> Tenderness
RESPIRATORY
<input type="checkbox"/> Shortness of breath upon exertion
<input type="checkbox"/> Cough
<input type="checkbox"/> Wheezing
<input type="checkbox"/> Other
MEN ONLY
<input type="checkbox"/> Lump in testicles
<input type="checkbox"/> Penis discharge
<input type="checkbox"/> Prostate problems
LYMPHATIC
<input type="checkbox"/> Swollen glands
WOMEN ONLY
<input type="checkbox"/> Currently pregnant
Last menstrual period _____
of prior pregnancies _____
Number of live births _____ |
|---|---|--|--|

PLEASE CHECK HERE TO VERIFY THAT ALL UNMARKED ITEMS ARE NEGATIVE

PERSONAL MEDICAL HISTORY

PERSONAL MEDICAL HISTORY

- | | | | |
|--------------------------------------|---|--|--|
| <input type="checkbox"/> HIV / AIDS | <input type="checkbox"/> Cataracts | <input type="checkbox"/> Emphysema/COPD | <input type="checkbox"/> MRSA |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Coronary Disease | <input type="checkbox"/> Epilepsy/Seizures | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Heart attack, Stents, | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Congestive Heart Failure | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Sleep Apnea |
| <input type="checkbox"/> Blood Clots | <input type="checkbox"/> Crohn's Disease | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Tuberculosis |

PLEASE CHECK HERE TO VERIFY THAT ALL UNMARKED ITEMS ARE NEGATIVE

COMMENTS: _____

FAMILY HISTORY

Check and list relationship on the line below if ANYONE IN YOUR FAMILY has a history of the following:

- | | | | |
|---------------------------------|-----------------------------------|--|---|
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Other Problems (explain below) |
| _____ | _____ | _____ | _____ |
| Relationship & Type | Relationship | Relationship | Relationship |

Please explain _____

PLEASE CHECK HERE TO VERIFY THAT ALL UNMARKED ITEMS ARE NEGATIVE

Please complete second page of questionnaire

HOSPITALIZATIONS/SURGERIES

Please list any hospitalizations surgeries, biopsies/procedures. _____ Please check here if no previous surgeries.

YEAR

HOSPITALIZATION / SURGERY

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

HEALTH HABITS/SOCIAL HISTORY

Check the following regarding your current or past health habits:

Tobacco use/Smoke: ___ Yes ___ No ___ Former
If former, year quit: _____

Street/Recreational Drug Use: ___ Yes ___ No ___ Former
If yes or former, type and year quit: _____

Alcohol: ___ Yes ___ No
If yes, frequency and amount _____

Exercise: ___ Yes ___ No
If yes, frequency and amount _____

Have you ever had an H.I.V. (AIDS) test? _____ IF YES, the results were: _____

CURRENT MEDICATIONS

Please list all prescription and nonprescription medications. Please include all vitamins, supplements, aspirin, birth control medications, laxatives and medicines taken "as needed".

Medicine	Dose	Medicine	Dose
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

ALLERGIES

Do you have any allergies to medicines, foods, latex, iodine, contrast dye, etc.?.

_____ Check if no known drug allergies.

_____ Check if no latex allergy

Please complete the following to provide us with information regarding your allergies.

Name of Allergen	What type of Reaction
_____	_____
_____	_____
_____	_____

To the best of my knowledge, all the information provided regarding my health is complete and correct. I understand that it is my responsibility to inform Mid Michigan Surgeons if I have any changes in my health, or health information.

Patient's Printed Name

Signature of Patient (or Representative)

Date