Internal Medicine Comprehensive New Patient Health History Questionnaire

Full Name: ______________________________ Address: ______________________________

Date of birth: _____________ Age: _____ Sex: ______ City/State/Zip: ______________________________

Primary phone number: ______________________________

Primary e-mail address: ______________________________

Main reason for today's visit (*mark one*)

- ☐ Annual Physical/Health Screening
- ☐ Medicare Wellness Visit
- ☐ Addiction Treatment
- ☐ Other:

Other concerns you have (may require separate appointment(s)):

____

Most recent primary physician or health care provider

Name of practitioner: ____

Type of practitioner: ____

- ☐ Physician (M.D. or D.O.)
- ☐ Nurse Practitioner (NP, DNP, FNP, CNP, ARNP)
- ☐ Physician Assistant (PA-C)
- ☐ Don't know

Address: ____

City/State/Zip: ____

Do you plan to keep the above individual as your primary care provider?

☐ Yes ☐ No

Other healthcare practitioners you see regularly

Name of practitioner: ____________________________ Name of practitioner: ____________________________

Specialty/field: ____________________________ Specialty/field: ____________________________

Address: ____________________________ Address: ____________________________

City/State/Zip: ____________________________ City/State/Zip: ____________________________

Demographic Information

Occupational status

□ Employed □ Retired □ Unemployed □ Homemaker □ Full-time student

If employed, what is the nature of your job/work?

____

Do you receive disability benefits?

□ Yes □ No

(If yes to above) Describe the medical condition for which you qualified for disability.

____

Marital status

□ Single □ Married □ Divorced □ Legally separated □ Widowed

Spouse/partner name: _________________________ Number of children: _______

Who lives at home with you?

____

What is your education level?

□ Didn’t complete high school □ Graduated high school □ 2 years college or trade school

□ 4 years college □ Graduate school or advanced degree

What is your country of birth?

____

Have you travelled out of the country in the last 12 months? (If yes, please state where)

□ No □ Yes, to: _______________________________

Are you a veteran of the armed services?

□ Yes □ No

Substance Use History

(*Addiction treatment patients: skip this page*)

Tobacco

 Never Smoker Former Smoker Current Smoker

 Use chewing tobacco or snus/dip

If former or current smoker:

How many years have you (or did you) used tobacco? ______________________

How many packs do you (or did you) smoke per day (on average)? ______________________

 I am a current smoker and I would like help quitting

Alcohol

 Never Drinker Former Drinker Current Drinker

How many drinks* per day (on average)? ______________________
(**1 drink = 1 can of beer, 1 glass of table wine, 1 shot of hard liquor*)

Marijuana

 Never User Former User Current User

Methamphetamine

 Never User Former User Current User

Cocaine

 Never User Former User Current User

Opioids (*heroin, fentanyl, oxycodone, etc.—answer if obtained illegally, not through a legal prescription*)

 Never User Former User Current User

 I am a current opioid addict, and I would like help quitting.

Benzodiazepines (*Xanax, Valium, Ativan, etc.—answer if obtained illegally, not through a legal prescription*)

 Never User Former User Current User

What other psychoactive substances have you used in the past or currently use?

____

Past Medical History

Please mark the medical problems you have dealt with (now or in the past).

Condition	Now	Past	Comments
Alcohol abuse			
Allergy (Hay Fever)			
Anemia			
Anxiety disorder			
Arthritis			
Asthma			
Atrial fibrillation			
Bladder problems (explain in comments)			
Blood clot (leg or lung)			
Cancer of blood (lymphoma, leukemia)			
Cancer of breast			
Cancer of colon or rectum			
Cancer of lung			
Cancer of prostate			
Cancer of other type (specify)			
Chronic kidney disease			
Coronary artery disease or heart attack			
Depression			
Diabetes (specify which type, 1 or 2)			
Diverticulitis			
Emphysema (COPD)			
Gallbladder disease			
Gastroesophageal reflux disease/heart burn			
Gout			
Hepatitis B			
Hepatitis C			
Heart failure			
High blood pressure (hypertension)			
High cholesterol			
Hip fracture			
Irritable bowel syndrome			
Kidney stones			
Liver disease			
Migraines			
Osteoporosis			
Prostate enlargement (BPH)			
Seizures/epilepsy			
Skin cancer			
Skin condition (describe)			
Sleep apnea			
Stomach ulcer			
Stroke			
Thyroid disease (overactive/hyperthyroidism)			
Thyroid disease (underactive/hypothyroidism)			

What other medical problems have you been diagnosed with?

___

Past Surgical/Procedural History

Please mark the surgeries or procedures you have undergone. List any abnormal findings, details, or complications in the comments section.

Surgery or Procedure	Yes	Year of Procedure	Comments
Abdominal surgery			
Angiogram of heart			
Angiogram of blood vessel			
Appendectomy (removal of appendix)			
Back surgery			
Biopsy (detail anatomic location in comments)			
Breast augmentation			
Breast removal (mastectomy)			
Cataract surgery			
Coronary bypass surgery (CABG)			
Echocardiogram (heart ultrasound)			
EGD (stomach/esophageal endoscopy)			
Electroconvulsive therapy (ECT)			
Gallbladder removal			
Heart surgery (other than CABG)			
Hip replacement surgery			
Hysterectomy (partial, still have ovaries)			
Hysterectomy (total, including ovaries)			
Neck surgery			
Sinus surgery			
Spinal surgery			
Stress test (cardiac)			
Thyroid removal			
Tonsil removal			
Tubal ligation			

What other surgeries or procedures have you undergone? (please also list where and when)

____

____

____

____

What are your medication allergies or intolerances? (please state what reaction you had, e.g. rash)

____

____

____

____

Health Screening Procedures

The following are common health maintenance and cancer screening procedures. Please state the month and year of the most recent procedure. Please also detail any abnormal findings.

Procedure	Year	Findings?
Colonoscopy (colorectal cancer screening)		
Mammogram (breast cancer screening)		
CT scan of lungs (lung cancer screening)		
PSA blood test (prostate cancer screening)		
Pap smear (cervical cancer screening)		
Full-body skin exam by dermatologist (skin cancer and melanoma screening)		
Abdominal aorta ultrasound (abdominal aortic aneurysm screening)		
DEXA scan (bone density screening)		
Hepatitis C screening		
HIV screening		

Immunization History

The following are common immunizations. Please state the month and year of each administration, if remembered.

Vaccine	Month and year
Influenza (Flu)	☐ Never received ☐ Don’t remember
Tetanus booster (Td)	☐ Never received ☐ Don’t remember
Shingrix (shingles)	☐ Never received ☐ Don’t remember
Pneumococcal (“Pneumonia shot”)	☐ Never received ☐ Don’t remember
HPV (Gardasil)	☐ Never received ☐ Don’t remember
Meningococcal	☐ Never received ☐ Don’t remember
Tuberculosis (BCG)	☐ Never received ☐ Don’t remember
Hepatitis A	☐ Never received ☐ Don’t remember
Hepatitis B	☐ Never received ☐ Don’t remember
MMR	☐ Never received ☐ Don’t remember

My immunization records are on file with:

Name of practitioner: ________________________________

Specialty/field: ________________________________

Address: ________________________________

City/State/Zip: ________________________________

☐ Check this box if records are on file with the most recent primary care provider written on page 1.

Family Medical History

Please mark the diagnoses your family members have received (blood relatives only).

If you are adopted, please check this box: ☐

Condition	Father	Mother	Other relative(s) (please specify)
Alcohol abuse			
Alzheimer disease			
Anxiety disorder			
Arthritis			
Asthma			
Bipolar disorder			
Blood clot (leg or lung)			
Cancer of blood (lymphoma, leukemia)			
Cancer of breast			
Cancer of colon or rectum			
Cancer of ovary			
Cancer of prostate			
Cancer of other type (specify)			
Coronary artery disease or heart attack			
Crohn disease or ulcerative colitis			
Cystic fibrosis			
Depression			
Diabetes (specify which type, 1 or 2)			
Emphysema (COPD)			
Heart failure			
High blood pressure (hypertension)			
High cholesterol			
Hip fracture			
Melanoma			
Seizures/epilepsy			
Sudden cardiac death			
Stroke			
Thyroid disease (overactive/hyperthyroidism)			
Thyroid disease (underactive/hypothyroidism)			

What other family medical history would you like us to know about?

____

____

____

____

Miscellaneous Questions

Do you have a living will?

 Yes No I don't know what that is

Do you have a healthcare power of attorney?

 Yes No I don't know what that is

An out-of-hospital do-not-resuscitate (DNR) order form instructs emergency medical personnel to withhold the administration of cardiopulmonary resuscitation (CPR) to a patient whose heart or breathing has stopped. This type of medical order is often requested by individuals who would prefer to die naturally and avoid the suffering of resuscitative treatments. A DNR is recommended for patients who are far more likely to suffer harm from CPR than to return to their pre-cardiac arrest quality-of-life (e.g. patients with advanced medical problems, frail elderly patients, etc.).

 I already have an out-of-hospital DNAR form on-file

 I wish to speak to my physician/provider about an out-of-hospital DNAR

 I am not interested

Do you follow a special diet? Yes No
(*Check all that apply*)

 Vegetarian Vegan Gluten-free Low Carb, High Fat (LCHF)

 Intermittent Fasting Ketogenic FODMAP Other: ____________________

Do you exercise regularly? Yes No

What kind of exercise? ___________________________________

How many days per week do you exercise? _____ How long are your exercise sessions? __________

Over the last 2 weeks, how often have you been bothered by the following problems?

1. Little interest or pleasure in doing things.

 Not at all Several days More than half the days Nearly every day

2. Feeling down, depressed, or hopeless.

 Not at all Several days More than half the days Nearly every day

At any time, has a partner ever hit you, kicked you, or physically hurt you?

 Yes No