



Clive Albert MD AGAF
Arumugam Natesan MD

New Patient Questionnaire

Name: _____ Date: _____

Date of Birth: _____ Age: _____

Referring Physician: _____

REASON FOR VISIT TODAY: _____

PAST MEDICAL HISTORY <i>Check if you have a history of any problems listed below</i>		
<input type="checkbox"/> Heart failure	<input type="checkbox"/> Anemia	<input type="checkbox"/> Kidney disease
<input type="checkbox"/> Heart attack	<input type="checkbox"/> Ulcers	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Irregular heart beat	<input type="checkbox"/> Colon cancer	<input type="checkbox"/> HIV/AIDS
<input type="checkbox"/> Heart murmur	<input type="checkbox"/> Colon polyps	<input type="checkbox"/> Arthritis
<input type="checkbox"/> Antibiotics before dental work	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Glaucoma
<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Ulcerative Colitis	<input type="checkbox"/> Stroke
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Crohn's Disease	<input type="checkbox"/> Seizure Disorder
<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Irritable/spastic bowel	<input type="checkbox"/> Depression
<input type="checkbox"/> COPD/Emphysema/ Asthma	<input type="checkbox"/> Breast cancer	<input type="checkbox"/> Anxiety
<input type="checkbox"/> Thyroid problems	<input type="checkbox"/> Prostate cancer	<input type="checkbox"/> Endometriosis
<input type="checkbox"/> Clotting disorders	<input type="checkbox"/> Uterine cancer	<input type="checkbox"/> Other _____
<input type="checkbox"/> Blood Transfusion	<input type="checkbox"/> Other cancer _____	

PAST SURGICAL HISTORY <i>Check if you have had any of the surgeries below and list year of your surgery</i>	
<input type="checkbox"/> Gallbladder removal	<input type="checkbox"/> Mastectomy/Lumpectomy
<input type="checkbox"/> Appendectomy	<input type="checkbox"/> Hysterectomy
<input type="checkbox"/> Colon or bowel resection	<input type="checkbox"/> Ovary removal
<input type="checkbox"/> Ulcer surgery	<input type="checkbox"/> C-Section
<input type="checkbox"/> Artificial Joint	<input type="checkbox"/> Tubal ligation
<input type="checkbox"/> Heart bypass	<input type="checkbox"/> Hernia Repair
<input type="checkbox"/> Artificial heart valve	<input type="checkbox"/> Hemorrhoid removal
<input type="checkbox"/> Other _____	<input type="checkbox"/> Other _____

CURRENT MEDICATIONS *Include prescription, over the counter, home and herbal remedies*

MEDICATION ALLERGIES *Include type of reaction* No known allergies

FAMILY MEDICAL HISTORY <i>Check if a blood relative has had a history of any problems listed below</i>		
<input type="checkbox"/> Heart disease	<input type="checkbox"/> Colon cancer	<input type="checkbox"/> Liver disease
<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Colon polyps	<input type="checkbox"/> Pancreatic problem
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Ulcers	<input type="checkbox"/> Gallbladder problem
<input type="checkbox"/> Breast cancer	<input type="checkbox"/> Ulcerative Colitis	<input type="checkbox"/> Anemia
<input type="checkbox"/> Uterine cancer	<input type="checkbox"/> Crohn's Disease	<input type="checkbox"/> Other _____
<input type="checkbox"/> Other _____	<input type="checkbox"/> Stomach cancer	<input type="checkbox"/> Other _____



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SOCIAL HISTORY

Smoking: None now None ever
 Currently how many/day? _____ # of years? _____
 In past how many/day? _____ # of years? _____
 When did you quit? _____

Alcohol: None now None ever
 How many cocktails/beer/wine _____ daily/ weekly/ monthly/ yearly (Circle one)

Cups of coffee/day _____ Caffeinated soft drinks/day _____

History of recreational drug use? None IV drugs _____ Intranasal _____

Type of Employment _____

Marital Status: Single Married Divorced Widowed Domestic partnership

Children ages and health _____

REVIEW OF SYSTEMS <i>Check symptoms you are currently having or have had in the last 3 months</i>		
<input type="checkbox"/> Fatigue <input type="checkbox"/> Dizziness <input type="checkbox"/> Weight loss-unintended <input type="checkbox"/> Weight gain <input type="checkbox"/> Fever <input type="checkbox"/> Rash <input type="checkbox"/> Itching <input type="checkbox"/> Jaundice/Yellowing of eyes <input type="checkbox"/> Swelling in neck <input type="checkbox"/> Sores in mouth <input type="checkbox"/> Ringing in ears <input type="checkbox"/> Vision problems <input type="checkbox"/> Difficulty hearing <input type="checkbox"/> Nose bleeds <input type="checkbox"/> Pain in throat <input type="checkbox"/> Hoarseness <input type="checkbox"/> Cough <input type="checkbox"/> Shortness of breath o with exertion o when laying down o at night when sleeping <input type="checkbox"/> Wheezing <input type="checkbox"/> Chest pain <input type="checkbox"/> Swelling in legs <input type="checkbox"/> Pain in calf when walking	<input type="checkbox"/> Nausea <input type="checkbox"/> Vomiting <input type="checkbox"/> Loss of appetite <input type="checkbox"/> Heartburn <input type="checkbox"/> Pain when swallowing <input type="checkbox"/> Food sticking in chest <input type="checkbox"/> Abdominal pain o after eating o before eating o at night <input type="checkbox"/> Abdominal bloating/swelling <input type="checkbox"/> Diarrhea o At night <input type="checkbox"/> Constipation <input type="checkbox"/> Blood in stool <input type="checkbox"/> Oily stools <input type="checkbox"/> Rectal pain/pressure <input type="checkbox"/> Leakage of stool <input type="checkbox"/> Loss of bladder control o when coughing/laughing <input type="checkbox"/> Burning with urination <input type="checkbox"/> Frequent urination <input type="checkbox"/> Blood in urine <input type="checkbox"/> Urinating at night <input type="checkbox"/> Easy bruising	Men: <input type="checkbox"/> Slow urine stream <input type="checkbox"/> Difficulty with erection Women: <input type="checkbox"/> Last period _____ <input type="checkbox"/> Irregular periods <input type="checkbox"/> Heavy menstrual bleeding <input type="checkbox"/> Painful intercourse <input type="checkbox"/> Joint pain/swelling <input type="checkbox"/> Nervousness <input type="checkbox"/> Depression <input type="checkbox"/> Difficulty sleeping <input type="checkbox"/> Blackouts <input type="checkbox"/> Headaches <input type="checkbox"/> Difficulty speaking <input type="checkbox"/> Weakness in arm or legs <input type="checkbox"/> Tremors <input type="checkbox"/> Loss of body hair <input type="checkbox"/> Increased thirst <input type="checkbox"/> Heat or cold intolerant <input type="checkbox"/> Other _____ <input type="checkbox"/> All others negative

Patient signature _____ MD/PA signature _____