New Patient Questionnaire

Name: _____ **Date of Birth**: _____ **Phone Number**: _____

Referring Doctor: _____ Primary Doctor/Gynecologist: _____

Cardiologist (if applicable): _____ Last visit with Cardiologist (approx.): _____

Medical Conditions: (Circle all that apply)

High Blood Pressure	Asthma	Diabetes	Arthritis
Heart Attack	COPD	Hypothyroidism	Osteoporosis
Irregular Rhythm	Sleep Apnea	Kidney Disease	Depression
Heart Failure	Pulmonary Embolism	Liver Disease	Anxiety
Stroke	DVT	Gastric Reflux	Bipolar
High Cholesterol	Cancer	Crohn's or U. Colitis	Dementia
Other:			

Previous Surgeries:

Date	Operation

Gynecologic History:

Bra Size: _____ Date of Last Mammogram: _____ Where? _____

Previous Abnormal Breast Biopsy? yes or no Age at First Period: _____ Age at Menopause: _____ or n/a

Age at First Childbirth: _____or n/a Number of Children: _____ Number of Pregnancies: _____

History of Hormone Replacement: yes or no Current User: yes or no Years Used: _____

Family History:

Number of Paternal aunts: _____ Number of Sisters: _____

Number of Maternal aunts: _____ Number of Daughters: _____

List all relatives with cancer, i.e. breast, ovarian, colon, melanoma, prostate, pancreatic, etc.

Relation	Maternal or Paternal	Type of Cancer	Age at Diagnosis

New Patient Questionnaire Continued

Social History: (Circle all that apply)

Smoker? yes, no, former | Illicit drugs? yes or no | Alcohol use? often, occasional rare, none

Marital Status: _____ | Religion: _____ | Occupation: _____

Review of Systems: (Circle all that apply)

Weight Loss	Constipation	Insomnia
Weight Gain	Diarrhea	Anxiety
Feeling poor (Malaise)	Rectal Bleeding	Depression
Chills	Nausea	Dizziness
Fever >101	Vomiting	Falls
Hoarseness	Urinary Incontinence	Confusion
Hearing Loss	Urinary Frequency	Numbness
Chest Pain	Menstrual Irregularity	Headaches
Palpitations	Vaginal Discharge	Always thirsty
Leg Swelling	Vaginal Dryness	Joint Pain
Shortness of Breath	Hot Flashes	Back Pain
Cough	Itching	Neck Pain
Abdominal Pain	Rash	Muscle Aches
Other:		