



NEW PATIENT QUESTIONNAIRE

(Kimberly Coonfield, MD)

Date: _____

Name: _____

Please circle current medical problems:

Hypertension	High Cholesterol
Diabetes	Kidney problems
COPD	Asthma
GERD	Cancer
Heart disease	Liver problems
Other:	

PAST SURGICAL HISTORY:

Gallbladder	Appendix
Hysterectomy	Tonsillectomy
Other:	

Please list other doctors who are also currently treating you:

Past medical history: Please list all hospitalizations, major illnesses and surgeries:

Who lives with you in your home? _____

Your occupation: _____

Smoking history: Never smoked _____ Started (age) _____ Stopped (age) _____

 On average, packs per day? _____ Do you want to quit? _____

Do you drink alcoholic beverages? _____ If yes, how much? _____

Have you ever used illegal drugs? _____

Family history:

	Age if living	Age at death	Health problems or cause of death
Mother			
Father			
Brothers/Sisters			
Children			
Other			

*Please include cancer, diabetes, heart problems, high blood pressure, strokes, and other important illnesses.

Check if you've had	VACCINATIONS	Date of last one		Check if you've had	TESTS	Date of Last one
	Tetanus				Colonoscopy	
	Influenza (flu)				Bone density	
	Pneumonia				Mammogram	
	Hepatitis A				Pap smear	
	Hepatitis B				PSA	
	Shingles				Eye exam	
	Other (list)					

Please list the best phone number to call with test results: _____

Is it ok to leave a message? _____

Name/phone number of pharmacy: _____



Please check any of the following that you have experienced in the last month:

- | | | |
|---|---|---|
| <input type="checkbox"/> Weight change | <input type="checkbox"/> Constipation | <input type="checkbox"/> Increased hunger |
| <input type="checkbox"/> Fever or chills | <input type="checkbox"/> Heartburn | <input type="checkbox"/> Swollen glands |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Difficulty swallowing | <input type="checkbox"/> Bruising |
| <input type="checkbox"/> Poor appetite | <input type="checkbox"/> Rectal bleeding | <input type="checkbox"/> Easy bleeding |
| <input type="checkbox"/> Blurred vision | <input type="checkbox"/> Black tarry stool | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Eye pain | <input type="checkbox"/> Blood in urine | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Double vision | <input type="checkbox"/> Painful urination | <input type="checkbox"/> Runny nose |
| <input type="checkbox"/> Eye itching | <input type="checkbox"/> Urinating too often | <input type="checkbox"/> Nasal Congestion |
| <input type="checkbox"/> Earache | <input type="checkbox"/> Too much urine | <input type="checkbox"/> Tuberculosis in past |
| <input type="checkbox"/> Hearing problem | <input type="checkbox"/> Getting up at night to urinate | <input type="checkbox"/> Positive skin test for tuberculosis |
| <input type="checkbox"/> Hoarseness | <input type="checkbox"/> Muscle pain | <input type="checkbox"/> Blood clot in past |
| <input type="checkbox"/> Ringing in ears | <input type="checkbox"/> Joint pain | <input type="checkbox"/> Asbestos exposure |
| <input type="checkbox"/> Runny nose | <input type="checkbox"/> Swelling in arms or legs | <input type="checkbox"/> Pancreatitis |
| <input type="checkbox"/> Nose bleeds | <input type="checkbox"/> Decreased joint mobility | <input type="checkbox"/> Gallbladder problems |
| <input type="checkbox"/> Mouth sores | <input type="checkbox"/> Skin rash | <input type="checkbox"/> Colon polyps |
| <input type="checkbox"/> Sore throat | <input type="checkbox"/> Itching | <input type="checkbox"/> Radiation treatments to head or neck |
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> Dry skin | <input type="checkbox"/> Previous herpes |
| <input type="checkbox"/> Pounding heart beat | <input type="checkbox"/> Breast pain or lump | <input type="checkbox"/> Previous gonorrhea, syphilis, or chlamydia infection |
| <input type="checkbox"/> Irregular heart beat | <input type="checkbox"/> Headache | |
| <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Dizziness | |
| <input type="checkbox"/> Fainting | <input type="checkbox"/> Weakness | |
| <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Pain (location _____) | |
| <input type="checkbox"/> Cough | <input type="checkbox"/> Numbness | |
| <input type="checkbox"/> Wheezing | <input type="checkbox"/> Stroke or seizure in past | |
| <input type="checkbox"/> Snoring | <input type="checkbox"/> Depression | |
| <input type="checkbox"/> Abdominal pain | <input type="checkbox"/> Anxiety | |
| <input type="checkbox"/> Nausea | <input type="checkbox"/> Stressed | |
| <input type="checkbox"/> Vomiting | <input type="checkbox"/> Hallucinations | |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Increased thirst | |

Women only: Date of last menstrual period Abnormal vaginal bleeding
 Vaginal discharge Previous abnormal Pap smear
 Sexual difficulties

Men only: Pain or lump on testicle Discharge from penis
 Prostate problems Sexual difficulties

