

General Internal Medicine



New Patient Questionnaire

Date: _____

Name: _____

What would you like to be called by the doctor? _____

Marital Status: _____

Please list how you would like to be contacted, for test results:

In case of emergency, contact: _____

Phone: _____ Relationship: _____

Allergies or Drug Reactions (Specify drug and reaction):

Current or recent medications (Include over-the-counter products, aspirin and vitamins):

Please list current medical problems:

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? (Spouse, Children, In-laws, Significant Others, etc.)

Your Occupation: _____

What are your hobbies? _____

Birthplace: _____ Education: _____

Have you recently traveled outside of Georgia? (If so, where?): _____

Do you get regular exercise: (describe):

Do you wear seat belts? Always Usually Occasionally Never

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

On average, how many packs per day? _____

Do you drink alcoholic beverages? _____ If yes, how many times in the last year have you
drank 4 or more drinks on one occasion? _____

Have you ever had a drinking problem? _____

How many cups of coffee or caffeinated drinks do you drink daily? _____

Do you use marijuana, cocaine, any street drugs or prescription drugs not prescribed for you?

Yes No **(Leave blank if you would rather discuss with doctor.)**

Family History:

	Age if living	Age at death	Health problems or cause of death
Mother			
Father			
(Brothers & Sisters)			
Children:			

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

Check if you've had	VACCINATIONS	Date of Last One
	Tetanus	
	Influenza (FLU shot)	
	Pneumonia	
	Hepatitis A	
	Hepatitis B	
	Shingles	
	Other (list)	

Check if you've had	TESTS	Date of Last One:
	Stool cards for colon cancer testing	
	Colonoscopy	
	Sigmoidoscopy	
	Bone density	
	Mammogram	
	Pap smear (women only)	
	PSA(men only)	
	Eye exam by eye doctor	

Please check any of the following that apply to you:

- | | | |
|---|---|---|
| <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"/> Gall bladder 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:
<input type="checkbox"/> Date of last menstrual period
<input type="checkbox"/> Abnormal vaginal bleeding
<input type="checkbox"/> Vaginal discharge
<input type="checkbox"/> Previous abnormal Pap smear
<input type="checkbox"/> Sexual difficulties

Men only:
<input type="checkbox"/> Pain or lump on testicle
<input type="checkbox"/> Discharge from penis
<input type="checkbox"/> Prostate problems
<input type="checkbox"/> Sexual difficulties