

Lakeview Internal Medicine & Surgery

New Patient Questionnaire

Name _____

Birthdate ____ / ____ / ____ Age ____

Marital Status M S W D Sex M F

Circle one: Student / Employed / Unemployed / Retired / Disability

Occupation _____

Employer/School _____

Daytime phone to reach you for test results: () ____ - ____

Who referred you to see us? _____

Previous doctors	Specialty	Address, Phone (if known)

Pharmacy name	City	Phone

Why are you coming to see us today?

Past/Current Medical Problems (use back of sheet if necessary)

1.	6.
2.	7.
3.	8.
4.	9.
5.	10.

Past Surgeries/Hospitalizations (use back of sheet if necessary)

Date

Past Surgeries/Hospitalizations (use back of sheet if necessary)	Date

Drug allergies

Reaction

Drug allergies	Reaction

Medications (including over the counter)

Dose

How Often?

Medications (including over the counter)	Dose	How Often?

Tobacco Use (circle one): No Yes Quit

Type (circle one): Cigarettes Pipe Cigars

If quit, how long ago? _____ Past use ___ ppd x _____ yrs

Current use _____ ppd since age _____

Alcohol Use (circle one): No Yes Quit

Circle all that apply: Beer Wine Liquor

Quantity: _____ per _____ (day, week...)

Name: _____ Today's Date: _____

Family History:

Father: deceased ___ alive, age ___ medical problems _____

Mother: deceased ___ alive, age ___ medical problems _____

Siblings, total number ___ medical problems _____

Do you have blood relatives who suffer with any the following? (circle all that apply)

Cancer	Diabetes	Alzheimer's
Bleeding tendency	Emphysema/COPD	Depression
High blood pressure	Asthma	Suicide
Heart attacks	Hay fever	Other mental illness
Heart failure	Kidney disease	Colitis
Stroke	Thyroid disease	Osteoporosis

Details: _____

Are YOU having problems with (circle all that apply)... ?

General	Hot / cold intolerance depression excessive tiredness weight gain weight loss ___ lbs over _____ (time period)
Skin	rashes sores that don't heal skin growths change in color Details _____ Easy bruising itching
Eyes	blurry vision double vision nearsighted farsighted cataracts glaucoma discharge redness
Ears	hearing loss ringing pain discharge
Nose	frequent/severe nosebleeds congestion discharge
Throat	hoarseness difficulty swallowing
Respiratory	cough coughing blood difficulty breathing wheezing
Cardiovascular	chest pain/tightness palpitations rapid/irregular heartbeat swelling in legs leg/foot cramps abnormal EKG
Gastrointestinal	abdominal pain nausea/vomiting loss of / excessive appetite Constipation diarrhea trouble swallowing heartburn black/bloody stools hemorrhoids loss of bowel control
Genital/Urinary	burning / frequent urination bloody urine thirsty all the time Frequent nighttime urination dribbling loss of bladder control Loss of sex drive penile/vaginal discharge testicular mass
Neurologic	numbness dizziness headaches insomnia seizures anxiety hallucinations suicidal thoughts Fainting falling memory loss confusion

Details of above / other: _____