GENESIS MEDICAL GROUP SM

NEW PATIENT MEDICAL QUESTIONNAIRE

NEW PATIENT MEDICAL QUESTIONS

Please complete this questionnaire by answering each question as accurately as possible.

GENERAL INFORMATION

Patient Name: _____ Date of Birth:_____ Sex: Male Female

Social Security:_____-_____- _____ Insurance Carrier:_____ Insurance ID#:_____

Address: _____ Phone: (____)_____-_____ Cell/Wk: (____)_____-_____

Referring Physician:_____ Primary Care Physician:_____

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widow ☐ Other_____

CHIEF COMPLAINT/REASON FOR VISIT

What is the reason for your visit today? _____

Are you experiencing any pain? (circle one) **YES** **NO** , if yes where is the pain location

_____

If you marked yes, please indicate on the scale of 1 to 10 with 10 being the highest, what is your level of pain **1 2 3 4 5 6 7 8 9 10**

MEDICATIONS

Please list all prescriptions and over-the-counter medication you take on a regular basis. **(If you have a list readily available, please give copy to the front desk)**

Medication Name	Dose (ex. 50mg)	Frequency (ex. once a day)	Reason for Taking

ALLERGIES

Are you allergic to any medications? **YES** **NO** if yes please list medications _____
Are you allergic to intravenous contrast? **YES** **NO** if yes please list your reaction_____
Any other allergies? Incl. Latex **YES** **NO** if yes please list_____

PHARMACY INFORMATION

Name: _____ _____ _____
Address: _____ _____

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SOCIAL HISTORY

1) Do you or have you EVER used tobacco products? (circle one) **YES** or **NO**, if yes please complete 1A – 1B, in no skip to 2.

1A. Select All That Apply:

- ☐ Current smoker, every day
- ☐ Current smoker, some days
- ☐ Smoker, status unknown
- ☐ Light tobacco smoker
- ☐ Heavy tobacco smoker
- ☐ Former Smoker

1B. Select All That Apply:

- ☐ Cigarettes Amount:_____per day
- ☐ Cigars Amount:_____per day
- ☐ Smokeless Amount:_____per day
- ☐ Pipes Amount:_____per day

2) Have you had exposure to second hand smoke? (circle one) **YES** or **NO**

3) Do you drink alcoholic beverages? (circle one) **YES** or **NO**, if yes how often _____

FAMILY MEDICAL HISTORY

Please list if any of your family members below have or had any of the following diseases or medical conditions: ***Bleeding/Clotting Disorders, Cancer (list type if known), Diabetes, Heart Disease, Hypertension, Leukemia, Lymphoma, Heart Attack, or stroke.***

Mother:	**Alive**	**Deceased** Age:_____		Medical Condition:_____
Father:	**Alive**	**Deceased** Age:_____		Medical Condition:_____
Sister(s):	**Alive**	**Deceased** Age:_____		Medical Condition:_____
Brother(s):	**Alive**	**Deceased** Age:_____		Medical Condition:_____
Grandmother:	**Maternal**	**Paternal**	Age:_____	Medical Condition:_____
Grandfather:	**Maternal**	**Paternal**	Age:_____	Medical Condition:_____
Aunts:	**Maternal**	**Paternal**	Age:_____	Medical Condition:_____
Uncles:	**Maternal**	**Paternal**	Age:_____	Medical Condition:_____

PAST MEDICAL HISTORY

1) Have you had any of the following tests within the last 6 months? (Select All That Apply, if yes where and when?)

- ☐ Pet Scan When_____ Where_____
- ☐ CT Scan When_____ Where_____
- ☐ Ultrasound When_____ Where_____
- ☐ Other (specify) When_____ Where_____

2) Have you been hospitalized in the last 6 months? **YES** **NO**

If YES, when_____and reason for hospitalization _____

3) Please list any additional information about your medical history that the physician should know:

_____

_____

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REVIEW OF SYSTEMS

Check the symptoms you currently have or have had in the past year. Please check all that apply.

GENERAL
___ Chills
___ Depression/Nervousness
___ Dizziness/Fainting
___ Excessive Weight Gain or Loss
___ Fever
___ Headache
___ Numbness

CARDIOVASCULAR
___ Chest Pain
___ High/Low Blood Pressure
___ Irregular/Rapid Heart Beat
___ Poor Circulation
___ Shortness Of Breath
___ Swelling In Ankles
___ Varicose Veins

SKIN
___ Any Chronic Rashes Or Eruptions
___ Change In Moles
___ Hives
___ Itching
___ Irregular Scars
___ Poor Healing Of Lesions or Wounds
___ Poor Healing Of Foot Lesions

EYE, EAR, NOSE, & THROAT
___ Bleeding Gums
___ Blurred Vision
___ Crossed Eyes
___ Difficulty Swallowing
___ Double Vision
___ Earache Or Ear Discharge
___ Hay Fever
___ Hoarseness
___ Loss of Hearing
___ Nosebleeds
___ Persistent Cough
___ Ringing In Ears
___ Sinus Problems
___ Vision – Flashes or Halos

GASTROINTESTINAL
___ Bloating
___ Black Or Tarry Stools
___ Bowel Changes
___ Change In Appetite
___ Constipation
___ Diarrhea
___ Excessive Thirst
___ Gas
___ Hemorrhoids
___ Indigestion/Heartburn
___ Nausea
___ Rectal Bleeding
___ Stomach Pain
___ Vomiting

HEMATOLOGIC
___ Anemia
___ Easy Bruising
___ Excessive Bleeding

RESPIRATORY
___ Chronic Cough
___ Coughing Up Blood
___ Wheezing Or Asthma

URINARY
___ Blood In Urine
___ Frequent Urination
___ Lack Of Bladder Control
___ Painful Urination

NEUROLOGICAL
___ Double Vision/Vision Loss
___ Prior Stroke
___ Muscular Weakness/Tingling
___ Speech Difficulty
___ Transient Paralysis
___ Transient Neurologic Deficit

MUSCLE/BONE/JOINT
Pain, Weakness, Numbness In:
___ Arms
___ Back
___ Feet
___ Hands
___ Hips
___ Legs
___ Neck/Shoulders

MEN ONLY
___ Erection Difficulties
___ Lump In Testicles
___ Penis Discharge
___ Sore On Penis
___ Other Issue_____

WOMEN ONLY
___ Abnormal Pap Smear
___ Bleeding Between Periods
___ Breast Lump
___ Extreme Menstrual Pain
___ Hot Flashes
___ Nipple Discharge
___ Painful Intercourse
___ Vaginal Discharge

Date of Last Period: _____
Date of Last Pap Smear: _____
Date of Last Mammogram:_____

Are you pregnant? Yes or No

Number of Children: _____

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REVIEW OF SYSTEMS CONTINUED

Check all the conditions you have or have had in the past.

___ Aids	___ Chicken Pox	___ HIV Positive	___ Polio
___ Appendicitis	___ Diabetes	___ Kidney Disease	___ Prostate Problem
___ Arthritis	___ Emphysema	___ Liver Disease	___ Rheumatic Fever
___ Asthma	___ Epilepsy	___ Measles	___ Scarlet Fever
___ Bleeding Disorders	___ Glaucoma	___ Migraine Headaches	___ Stroke
___ Breast Lump	___ Heart Disease	___ Multiple Sclerosis	___ Thyroid Problems
___ Cancer	___ Hepatitis	___ Mumps	___ Tuberculosis
___ Cataracts	___ Herpes	___ Pacemaker	___ Ulcers
___ Chemical Dependency	___ High Cholesterol	___ Pneumonia	___ Venereal Disease

SIGNATURES

To the best of my knowledge, the above information is complete and correct. I understand it is my responsibility to inform my doctor if I ever have a change in health.

_____ _____

Signature of Patient or Personal Representative **Date**

_____ _____

Print Name of Patient or Personal Representative **Relationship to Patient**