Internal Medicine
Cayuga Medical
Associates

ORIGINAL DATE: ____________________

DATES REVISED: ____________________

# NEW PATIENT HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

| Name (*Last, First, M.I.*): | | | | **M** ☐ **F** ☐ | DOB: |
|---|---|---|---|---|---|
| Marital Status: Single ☐ | Partnered ☐ | Married ☐ | Separated ☐ | Divorced ☐ | Widowed ☐ |
| Previous or Referring Doctor: | | | | | |
| **PERSONAL HEALTH HISTORY** | | | | | |
| Childhood Illness: Measles ☐ | Mumps ☐ | Rubella ☐ | Chickenpox ☐ | Rheumatic Fever ☐ | Polio ☐ |
| Immunizations & Dates: | Tetanus ☐ | | Pneumonia ☐ | | |
| | Hepatitis ☐ | | Chickenpox ☐ | | |
| | Influenza ☐ | | MMR (*Measles, Mumps, Rubella*) ☐ | | |
| Main problems/reasons for this consulatation: | | | | | |
| Additional problems or concerns you would like addressed: | | | | | |

NOTE: We may not be able to address every problem during the course of one consultation.

| **SURGERIES** | | |
|---|---|---|
| **YEAR** | **REASON** | **HOSPITAL** |
| | | |
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| | | |
| | | |
| | | |
| **OTHER HOSPITALIZATIONS** | | |
| **YEAR** | **REASON** | **HOSPITAL** |
| | | |
| | | |
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| | | |

| Have you ever had a **blood transfusion**? | YES ☐ | NO ☐ |
|---|---|---|

| Please list all of your **prescribed medications, including over-the-counter medications** such as vitamins and inhalers: | | |
|---|---|---|
| **NAME OF MEDICATION** | **STRENGTH** | **DOSAGE/FREQUENCY** |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

| Please list any **ALLERGIES TO MEDICATIONS:** | |
|---|---|
| **NAME OF MEDICATION** | **REACTION** |
| | |
| | |
| | |
| | |

| HEALTH HABITS & PERSONAL SAFETY | |
|---|---|
| All questions contained in this questionnaire are optional and will be kept strictly confidential. | |
| **EXERCISE:** | ☐ Sedentary (no exercise)<br>☐ Mild Exercise (i.e., climb stairs, walk 3 blocks, golf)<br>☐ Occasional Vigorous Exercise (i.e., work or recreation, less than 4x/week for 30 minutes)<br>☐ Regular Vigorous Exercise (i.e., work or recreation, 4x/week for 30 minutes) |
| **DIET:** | Are you dieting? YES ☐ NO ☐<br>If YES, are you on a physician prescribed meal diet? YES ☐ NO ☐<br>Number # of meals you eat in an average day?<br>Rank your SALT INTAKE High ☐ Medium ☐ Low ☐<br>Rank your FAT INTAKE High ☐ Medium ☐ Low ☐ |
| **CAFFEINE:** | None ☐ Coffee ☐ Tea ☐ Cola ☐<br>Number # of Cups/Cans per Day? ___________ |
| **ALCOHOL:** | Do you drink alcohol? YES ☐ NO ☐<br>If YES, what kind? _________________________<br>How many # drinks per week? _______________<br>Are you concerned about the amount you drinks? YES ☐ NO ☐<br>Have you considered stopping? YES ☐ NO ☐<br>Have you ever experienced blackouts? YES ☐ NO ☐<br>Are you prone to "binge" drinking? YES ☐ NO ☐<br>Do you drive after drinking? YES ☐ NO ☐ |
| **TOBACCO:** | Do you use tobacco? YES ☐ NO ☐<br>☐ Cigarettes (pks/day) _________ ☐ Chew (#/day) _________ ☐ Pipe (#/day) _______ ☐ Cigars (#/day) _________<br>Number # of Years _______________ **OR** Year you Quit __________________ |
| **DRUGS:** | Do you currently use recreational street drugs? YES ☐ NO ☐<br>Have you ever given yourself street drugs with a needle? YES ☐ NO ☐ |
| **SEXUAL ACTIVITY:** | Are you sexually active? YES ☐ NO ☐<br>If YES, are you trying for a pregnancy? YES ☐ NO ☐<br>If not trying for pregnancy, list the contraceptive or barrier method used: __________________________________<br>Do you experience any discomft during intercourse? YES ☐ NO ☐<br>Illness related to the Human Immunodeficiency Virus (HIV), such as AIDS, has become a major public health problem. Risk factors for this illness include intravenous drug use and unprotected sexual intercourse. Would you like to speak with your provider about your risk of this illness? YES ☐ NO ☐ |
| **PERSONAL SAFETY:** | Do you live alone? YES ☐ NO ☐<br>Do you have frequent falls? YES ☐ NO ☐<br>Do you have vision or hearing loss? YES ☐ NO ☐<br>Do you have an Advance Directive and/or Living Will? YES ☐ NO ☐<br>Would you like information on the preparation of these? YES ☐ NO ☐<br>Physical and/or mental abuse have also become major public health issues in this country. This often takes the form of verbally treatening behavior or actual physical or sexual abuse.<br>Would you like to discuss this issue with your provider? YES ☐ NO ☐ |

| FAMILY HEALTH HISTORY | | | | | |
|---|---|---|---|---|---|
| **RELATIONSHIP** | **AGE** | **SIGNIFICANT HEALTH PROBLEMS** | **RELATIONSHIP** | **AGE** | **SIGNIFICANT HEALTH PROBLEMS** |
| **FATHER** | | | **CHILD**<br>M ☐ F ☐ | | |
| **MOTHER** | | | **CHILD**<br>M ☐ F ☐ | | |
| **SIBLING**<br>M ☐ F ☐ | | | **CHILD**<br>M ☐ F ☐ | | |
| **SIBLING**<br>M ☐ F ☐ | | | **CHILD**<br>M ☐ F ☐ | | |
| **SIBLING**<br>M ☐ F ☐ | | | **GRANDMOTHER**<br>(Maternal) | | |
| **SIBLING**<br>M ☐ F ☐ | | | **GRANDFATHER**<br>(Maternal) | | |
| **SIBLING**<br>M ☐ F ☐ | | | **GRANDMOTHER**<br>(Paternal) | | |
| **SIBLING**<br>M ☐ F ☐ | | | **GRANDFATHER**<br>(Paternal) | | |

| MENTAL HEALTH | | |
|---|---|---|
| Is stress a major problem for you? | YES ☐ | NO ☐ |
| Do you feel depressed? | YES ☐ | NO ☐ |
| Do you panic when stressed? | YES ☐ | NO ☐ |
| Do you have problems with eating or your appetite? | YES ☐ | NO ☐ |
| Do you cry frequently? | YES ☐ | NO ☐ |
| Have you ever attempted suicide? | YES ☐ | NO ☐ |
| Have you ever seriously thought about hurting yourself? | YES ☐ | NO ☐ |
| Do you have trouble sleeping? | YES ☐ | NO ☐ |
| Have you ever been to a counselor? | YES ☐ | NO ☐ |

| WOMEN ONLY | | |
|---|---|---|
| Age at onset of menstruation: | | |
| Date of last menstruation: | | |
| Period every __________ days | | |
| Do you have heavy periods, irregularity, spotting, pain, or discharge? | YES ☐ | NO ☐ |
| Number of pregnancies: ________________ Number of live births: _________________ | | |
| Are you pregnant or breast feeding? | YES ☐ | NO ☐ |
| Have you had a D&C, hysterectomy, or Caesarean? | YES ☐ | NO ☐ |
| Any urinary tract, bladder, or kidney infections within the last year? | YES ☐ | NO ☐ |
| Any blood in your urine? | YES ☐ | NO ☐ |
| Any problems with control of urination? | YES ☐ | NO ☐ |
| Any hot flashes or sweating at night? | YES ☐ | NO ☐ |
| Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around time of period? | YES ☐ | NO ☐ |
| Have you experienced any recent breast tenderness, lumps, or nipple discharge? | YES ☐ | NO ☐ |
| What is the date of your last PAP and rectal exam? ___________________________ | | |

| MEN ONLY | | |
|---|---|---|
| Do you usually get up to urinate during the night? | YES ☐ | NO ☐ |
| If YES, how many times/night? _____________________ | | |
| Do you feel pain or burning when you urinate? | YES ☐ | NO ☐ |
| Is there any blood in your urine? | YES ☐ | NO ☐ |
| Do you feel burning discharge from your penis? | YES ☐ | NO ☐ |
| Has the force of your urination decreased? | YES ☐ | NO ☐ |
| Have you had any kidney, bladder, or prostate infections within the last 12 months? | YES ☐ | NO ☐ |
| Do you have any problems emptying your bladder completely? | YES ☐ | NO ☐ |
| Any difficulty with erection or ejaculation? | YES ☐ | NO ☐ |
| Any testicle pain or swelling? | YES ☐ | NO ☐ |
| What was the date of your last prostate and rectal exam? ___________________________ | | |

| OTHER PROBLEMS | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Please check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain. | | | | | | | | |
| Skin | YES ☐ | NO ☐ | Chest/Heart | YES ☐ | NO ☐ | Any recent changes in: | | |
| Head/Neck | YES ☐ | NO ☐ | Back | YES ☐ | NO ☐ | Weight | YES ☐ | NO ☐ |
| Ears | YES ☐ | NO ☐ | Intestinal | YES ☐ | NO ☐ | Energy Level | YES ☐ | NO ☐ |
| Nose | YES ☐ | NO ☐ | Bladder | YES ☐ | NO ☐ | Ability to Sleep | YES ☐ | NO ☐ |
| Throat | YES ☐ | NO ☐ | Bowel | YES ☐ | NO ☐ | Other Pain or Discomfort? | YES ☐ | NO ☐ |
| Lungs | YES ☐ | NO ☐ | Circulation | YES ☐ | NO ☐ | Explain: | | |