

Capstone Medical Group New Patient Questionnaire

Patient Name: _____

Date: _____

How did you hear about our office?

- Friend or Family. Name: _____
So that we may thank them
- Television Commercial
- Newspaper Ad
- Physician Referral. Name: _____
- Website Name: _____

Past Medical History: Please **CHECK** the “yes” box if any of the following illnesses apply.

	<u>Yes</u>	<u>No</u>			
High blood pressure	<input type="radio"/>	Yes <input type="radio"/>	No <input type="radio"/>	Peripheral vascular disease	<input type="radio"/>
Heart attack	<input type="radio"/>	Yes <input type="radio"/>	No <input type="radio"/>	Congestive Heart Failure	<input type="radio"/>
Atrial fibrillation	<input type="radio"/>	Yes <input type="radio"/>	No <input type="radio"/>	High cholesterol	<input type="radio"/>
Mitral Valve Prolapse	<input type="radio"/>	Yes <input type="radio"/>	No <input type="radio"/>	Heart Murmur	<input type="radio"/>
Diabetes	<input type="radio"/>	Yes <input type="radio"/>	No <input type="radio"/>	Hypothyroidism	<input type="radio"/>
Graves disease	<input type="radio"/>	Yes <input type="radio"/>	No <input type="radio"/>	Hyperthyroidism	<input type="radio"/>
Goiter	<input type="radio"/>	Yes <input type="radio"/>	No <input type="radio"/>		
Glaucoma	<input type="radio"/>	Yes <input type="radio"/>	No <input type="radio"/>	Diabetic Eye Disease	<input type="radio"/>
Cataracts	<input type="radio"/>	Yes <input type="radio"/>	No <input type="radio"/>		
GERD	<input type="radio"/>	Yes <input type="radio"/>	No <input type="radio"/>	Vitamin B 12 Deficiency	<input type="radio"/>
Hepatitis	<input type="radio"/>	Yes <input type="radio"/>	No <input type="radio"/>	Cirrhosis	<input type="radio"/>
Pancreatitis	<input type="radio"/>	Yes <input type="radio"/>	No <input type="radio"/>	Diverticulosis	<input type="radio"/>
Irritable Bowel Disorder	<input type="radio"/>	Yes <input type="radio"/>	No <input type="radio"/>	Stomach Ulcers	<input type="radio"/>
Colon polyps	<input type="radio"/>	Yes <input type="radio"/>	No <input type="radio"/>		
Arthritis	<input type="radio"/>	Yes <input type="radio"/>	No <input type="radio"/>	Gout	<input type="radio"/>
Lupus	<input type="radio"/>	Yes <input type="radio"/>	No <input type="radio"/>	Rheumatoid Arthritis	<input type="radio"/>
Depression	<input type="radio"/>	Yes <input type="radio"/>	No <input type="radio"/>	Schizophrenia	<input type="radio"/>
PTSD	<input type="radio"/>	Yes <input type="radio"/>	No <input type="radio"/>	Bipolar Disorder	<input type="radio"/>
Alzheimer’s Dementia	<input type="radio"/>	Yes <input type="radio"/>	No <input type="radio"/>		
Migraine headache	<input type="radio"/>	Yes <input type="radio"/>	No <input type="radio"/>	Carpal tunnel syndrome	<input type="radio"/>
Back pain	<input type="radio"/>	Yes <input type="radio"/>	No <input type="radio"/>	TIA	<input type="radio"/>

Stroke Yes No
Multiple Sclerosis Yes No

Seizures Yes No
Parkinson's Disease Yes No

Seasonal allergies Yes No

DVT Yes No
Sickle cell anemia Yes No
Anemia Yes No

Pulmonary embolism Yes No
Sickle cell trait Yes No

Kidney stones Yes No
Renal failure Yes No

Enlarged prostate Yes No

Osteoporosis Yes No
Polycystic ovarian syndrome Yes No
Heavy menstrual bleeding Yes No

Uterine fibroids Yes No
Endometriosis Yes No

Asthma Yes No
Sarcoidosis Yes No
Obstructive Sleep Apnea Yes No

Emphysema Yes No
Pneumonia Yes No

HIV/AIDS Yes No
Syphilis Yes No
Chlamydia Yes No

Genital herpes Yes No
Gonorrhea Yes No

Breast cancer Yes No
Colon cancer Yes No
Prostate cancer Yes No
Lung cancer Yes No

Ovarian cancer Yes No
Cervical cancer Yes No
Kidney cancer Yes No

Other conditions not listed above:

Surgical History: Please color the “yes” box to indicate if you have any of the following surgical procedures.

- | | | | |
|--------------------------|--|------------------------|--|
| Appendix removal | <input type="checkbox"/> Yes Date: _____ | Hysterectomy | <input type="checkbox"/> Yes Date: _____ |
| Heart bypass | <input type="checkbox"/> Yes Date: _____ | Mastectomy L_, R_ | <input type="checkbox"/> Yes Date: _____ |
| Gallbladder removal | <input type="checkbox"/> Yes Date: _____ | Knee replacement L_,R_ | <input type="checkbox"/> Yes Date: _____ |
| Hip replacement L__, R__ | <input type="checkbox"/> Yes Date: _____ | Cataract removal | <input type="checkbox"/> Yes Date: _____ |
| Heart valve replacement | <input type="checkbox"/> Yes Date: _____ | Thyroid removal | <input type="checkbox"/> Yes Date: _____ |
| Kidney removal | <input type="checkbox"/> Yes Date: _____ | Ovary removal | <input type="checkbox"/> Yes Date: _____ |
| Hernia repair | <input type="checkbox"/> Yes Date: _____ | Fibroid removal | <input type="checkbox"/> Yes Date: _____ |
| Prostate removal | <input type="checkbox"/> Yes Date: _____ | Carpel tunnel repair | <input type="checkbox"/> Yes Date: _____ |
| Rotator cuff repair | <input type="checkbox"/> Yes Date: _____ | ACL repair | <input type="checkbox"/> Yes Date: _____ |

Other surgeries and dates performed that are not listed above:

Allergies to any medications

Medication List

Social History

Smoking Yes No
Packs per day _____ Years smoked _____ Year quit _____

Second hand smoke expo Yes No

Alcohol Yes No
Exercise Yes No

Recreational drug use Yes No
What type _____

Sexually active Yes No
Recent travel outside US Yes No

Type of exercise _____
LMP _____ Last Pap _____

Review of Systems

General:	fever	<input type="radio"/> Yes <input type="radio"/> No	chills	<input type="radio"/> Yes <input type="radio"/> No
	weight gain	<input type="radio"/> Yes <input type="radio"/> No	weight loss	<input type="radio"/> Yes <input type="radio"/> No
	fatigue	<input type="radio"/> Yes <input type="radio"/> No		
ALLERGY;	runny nose	<input type="radio"/> Yes <input type="radio"/> No	itchy eyes	<input type="radio"/> Yes <input type="radio"/> No
	nasal congestion	<input type="radio"/> Yes <input type="radio"/> No	sneezing	<input type="radio"/> Yes <input type="radio"/> No
ENT:	nose bleeding	<input type="radio"/> Yes <input type="radio"/> No	hearing loss	<input type="radio"/> Yes <input type="radio"/> No
	ringing in ears	<input type="radio"/> Yes <input type="radio"/> No	sinus pain/drainage	<input type="radio"/> Yes <input type="radio"/> No
ENDO:	excessive thirst	<input type="radio"/> Yes <input type="radio"/> No	polyuria	<input type="radio"/> Yes <input type="radio"/> No
	cold intolerance	<input type="radio"/> Yes <input type="radio"/> No	heat intolerance	<input type="radio"/> Yes <input type="radio"/> No
	sore throat	<input type="radio"/> Yes <input type="radio"/> No		
LUNGS:	shortness of breath	<input type="radio"/> Yes <input type="radio"/> No	cough	<input type="radio"/> Yes <input type="radio"/> No
	wheezing	<input type="radio"/> Yes <input type="radio"/> No	snoring	<input type="radio"/> Yes <input type="radio"/> No
CARDIAC:	chest pain	<input type="radio"/> Yes <input type="radio"/> No	palpitations	<input type="radio"/> Yes <input type="radio"/> No
	dizziness	<input type="radio"/> Yes <input type="radio"/> No	leg edema	<input type="radio"/> Yes <input type="radio"/> No
GI:	heartburn	<input type="radio"/> Yes <input type="radio"/> No	jaundice	<input type="radio"/> Yes <input type="radio"/> No
	diarrhea	<input type="radio"/> Yes <input type="radio"/> No	constipation	<input type="radio"/> Yes <input type="radio"/> No
	nausea	<input type="radio"/> Yes <input type="radio"/> No	vomiting	<input type="radio"/> Yes <input type="radio"/> No
	trouble swallowing	<input type="radio"/> Yes <input type="radio"/> No	blood in stool	<input type="radio"/> Yes <input type="radio"/> No
GYN:	hot flashes	<input type="radio"/> Yes <input type="radio"/> No	heavy periods	<input type="radio"/> Yes <input type="radio"/> No
GU:	blood in urine	<input type="radio"/> Yes <input type="radio"/> No	frequent urination	<input type="radio"/> Yes <input type="radio"/> No
	incontinence	<input type="radio"/> Yes <input type="radio"/> No	weak stream	<input type="radio"/> Yes <input type="radio"/> No
	nocturia	<input type="radio"/> Yes <input type="radio"/> No		
HEME:	easy bruising	<input type="radio"/> Yes <input type="radio"/> No	night sweats	<input type="radio"/> Yes <input type="radio"/> No
	swollen glands	<input type="radio"/> Yes <input type="radio"/> No	swollen lymph nodes	<input type="radio"/> Yes <input type="radio"/> No
M/S:	back pain	<input type="radio"/> Yes <input type="radio"/> No	joint pain	<input type="radio"/> Yes <input type="radio"/> No
	leg cramps	<input type="radio"/> Yes <input type="radio"/> No	joint swelling	<input type="radio"/> Yes <input type="radio"/> No
NEURO:	headache	<input type="radio"/> Yes <input type="radio"/> No	numbness/tingling	<input type="radio"/> Yes <input type="radio"/> No
	insomnia	<input type="radio"/> Yes <input type="radio"/> No	memory loss	<input type="radio"/> Yes <input type="radio"/> No
	fainting/blackouts	<input type="radio"/> Yes <input type="radio"/> No	tremors	<input type="radio"/> Yes <input type="radio"/> No
EYE:	blurring of vision	<input type="radio"/> Yes <input type="radio"/> No	double vision	<input type="radio"/> Yes <input type="radio"/> No
	eye irritation/redness	<input type="radio"/> Yes <input type="radio"/> No	eye pain	<input type="radio"/> Yes <input type="radio"/> No
MEN ONLY:	Low sexual drive	<input type="radio"/> Yes <input type="radio"/> No	erectile dysfunction	<input type="radio"/> Yes <input type="radio"/> No