New Patient History Questionnaire – IDS

Date: ______________ Patient Name: ____________________________________ Date of Birth: __________________

NOTE TO PATIENT: INFORMATION CONTAINED HERE WILL NOT BE RELEASED UNLESS YOU AUTHORIZE US TO DO SO. THIS INFORMATION IS STRICTLY CONFIDENTIAL AND WILL ALLOW US TO PROVIDE BETTER CARE FOR YOU. PLEASE ANSWER THE QUESTIONS COMPLETELY ON BOTH SIDES OF THIS FORM.

Any medications you are now taking. Include over the counter and herbal medications.
List and give dosage. (Please bring these medicines with you for your appointment)

Medication Name	Dosage	Frequency

Allergies of any kind: ____

Past medical/surgical history: ______________________________ Advance Directives ☐Yes ☐No

Have you ever had any of the following:

	YES	NO		YES	NO
Heart Attack			Thyroid Disease		
High Blood Pressure			Stomach Ulcers		
Anemia			Hepatitis		
Gout			Colitis		
Strokes			Migraine Headaches		
Lung Problems			AIDS Testing		
Diabetes			Tuberculosis		
Cancer			STD's		
Kidney Problems			Other		

Operations:

List and indicate approximate year:

______________________ ________ ______________________ ________

______________________ ________ ______________________ ________

Hospitalizations:

List and indicate approximate year and nature of illness:

______________________ ________ ______________________ ________

______________________ ________ ______________________ ________

Other recent medical evaluations: ____

Family History:

	NAME	If living: AGE	HEALTH	If deceased: AGE AT DEATH	CAUSE
Father					
Mother					
Brothers/Sisters (check sex)					
☐M / ☐F					
☐M / ☐F					
☐M / ☐F					
☐M / ☐F					

Social History:

Married to: ____ for__________ years.
Number of children and ages: ________ ________ ________ ________ ________
Your Occupation: ____
Your level of education achieved: __________________________________
Amount of smoking: ________ packs per day for ________ years.
Amount of alcohol: ______________________________
Type of exercise or hobbies: ____

General:

Have any of these problems bothered you? Check YES or NO
Do you have a history of recurrent infections (for example skin boils, abscesses, sinus infections, pneumonia, bronchitis, wounds that do not heal well)? ☐YES ☐NO
Do you have a history of fever, night sweats, chills, unintentional weight loss, or swollen glands? ☐YES ☐NO
Do you have exposure to animals, either common household pets like dogs, cats, bird, or other animals like reptiles, bats, rabbits, raccoons or wild animals? ☐YES ☐NO
Do you know of any tick exposure? ☐YES ☐NO
Within the past year, have you traveled to:
Southwest USA ☐YES ☐NO
Northwest USA ☐YES ☐NO
Mexico ☐YES ☐NO
Europe ☐YES ☐NO
Africa ☐YES ☐NO
Central or South America ☐YES ☐NO
California, Arizona, Nevada, New Mexico, Texas ☐YES ☐NO
New York, Pennsylvania, Connecticut ☐YES ☐NO
Hawaii ☐YES ☐NO
Asia ☐YES ☐NO
Caribbean/Mediterranean ☐YES ☐NO
Have you ever had a TB skin test? ☐YES ☐NO If so, has it ever been positive? ☐YES ☐NO
If so, was it treated? ☐YES ☐NO
Have you ever been exposed to someone with active TB? ☐YES ☐NO

Have you ever had an HIV test? ☐YES ☐NO

Are your immunizations up-to-date? ☐YES ☐NO
☐ TDAP
☐ Varicella
☐ Meningococcal
☐ Hepatitis A and B

Have you ever in the past practiced any behaviors that would be considered "high risk" for infectious illnesses, such as:
Multiple sex partners (either same or opposite sex) ☐YES ☐NO
IV drug use ☐YES ☐NO
Sharing needles ☐YES ☐NO
Transfusions before 1992 ☐YES ☐NO
Non-professionally applied tattoos ☐YES ☐NO

Eyes:

Any eye problems: ____

ENT:
Do you have:

Ear problems?	☐YES ☐NO
Frequent or severe nosebleeds?	☐YES ☐NO

Respiratory:
Do you have:

Frequent chest colds?	☐YES ☐NO
A constant or bothersome cough?	☐YES ☐NO
Coughing of blood?	☐YES ☐NO
Sputum or phlegm between colds?	☐YES ☐NO
Difficulty breathing?	☐YES ☐NO
Have you noticed any wheezing or whistling in your chest?	☐YES ☐NO

Gastrointestinal:

Have you ever vomited blood?	☐YES ☐NO
Do you have diarrhea or constipation?	☐YES ☐NO
Have you ever passed blood from your rectum?	☐YES ☐NO
Have you ever had black or tarry stools?	☐YES ☐NO
Do you have frequent nausea and/or vomiting?	☐YES ☐NO

Genitourinary:
Do you have:

Anything wrong with your genitals (privates)?	☐YES ☐NO
Burning or pain when you urinate?	☐YES ☐NO
Trouble passing water?	☐YES ☐NO
Have you ever passed blood in your urine?	☐YES ☐NO

Musculoskeletal:

Do you have problems with arthritis or bursitis anywhere?	☐YES ☐NO

Central Nervous System:

Do you have frequent or severe headaches?	☐YES ☐NO
Do you consider yourself a nervous person?	☐YES ☐NO
Have you ever had the urge to commit suicide?	☐YES ☐NO

Patient Signature: ______________________ Date: __________ Time: __________

Physician Signature: ______________________ Date __________ Time: __________

If limited English proficient or hearing impaired, offer interpreter at no additional cost:

☐ Interpreter Accepted ______________________ ☐ Interpreter Refused

(Name/Number of Person/Services Chosen/Used)

Name / MR # / Label