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NEW PATIENT QUESTIONNAIRE

Name of Patient _____

Name of person completing form_____

1. WHAT MEDICATIONS ARE YOU CURRENTLY TAKING? In addition to your prescription medications, please include over-the-counter medications, vitamins and supplements.

☐ SEE MEDICATION LIST FROM FACILITY

NAME OF MEDICINE	DOSAGE (MG)	HOW MANY PER DAY?	TAKEN EVERY DAY OR AS NEEDED?

2. DO YOU HAVE ANY DRUG ALLERGIES?	O No	O Yes
NAME OF DRUG	WHAT HAPPENS WHEN YOU TAKE IT?	

3. PLEASE CHECK THE CONDITIONS THAT YOU HAVE HAD IN THE PAST OR CURRENTLY HAVE.

Alcohol abuse		Heart Disease	
Anemia		Heart murmur	
Angina		Hepatitis B	
Anxiety		Hepatitis C	
Aortic stenosis		Hernia	
Asthma		Hypercholesterolemia	
Atrial fibrillation		Hypertension	
Bladder or Kidney Infection		Insomnia	
Blood Clot in Leg		Irritable bowel syndrome	
Blood Clot in Lung		Irregular heart rhythm	
Blood Clots Elsewhere		Kidney Disease	
Carpal tunnel		Low back pain	
Cirrhosis		Macular degeneration	
Colitis / Diverticulitis		Migraine headache	
Congestive Heart Failure		Neuropathy	
Constipation		Obesity	
COPD/ Emphysema		Osteoarthritis	
Dementia		Osteoporosis	
Depression		Peptic ulcer disease	
Diabetes		Pneumonia	
Eczema		Scoliosis	
Edema		Seizures	
Enlarged Prostate		Shingles	
Enlarged Thyroid		Sleep apnea	
Fibromyalgia		Stroke	
GERD(Acid Reflux)		Thyroid Disease	
Gout		Tuberculosis	
Hay fever		Urinary incontinence	

- Please indicate any other past medical history not listed above:

_____

_____

CANCER					
	None				
	Uterine Cancer		Non-Hodgkin Lymphoma		Colon/Rectal Cancer
	Leukemia		Lung Cancer		Breast Cancer
	Ovarian Cancer		Prostate Cancer		Skin Cancer
	Urinary/Bladder Cancer		Other Cancer:		

PLEASE CIRCLE/LIST ANY SURGERIES YOU HAVE HAD:

Hysterectomy Appendix Gall Bladder Breast Prostate

Hip Replacement (R / L) Knee Replacement (R / L)

SURGERY	YEAR

- Has the patient had any hospitalizations in the last year?
  If so, please include the name of the hospital, city, state, and reason for hospitalization.

_____

_____

_____

_____

- Are you currently signed up with a Home Health Agency for nursing or physical therapy visits?
  (Circle one) YES / NO If Yes, with Whom _____

- When was the patient's last Bone Density Test? (circle one)
  1. Less than 2 years ago 2. More than 2 years ago 3. Never

- Does the patient have Osteoporosis? No _____ Yes _____

- Has the patient ever had fractures? No _____ Yes_____ Where? _____

- When was the patient's last Mammogram? (circle one)
  1. Less than one year ago 2. One year ago or more 3. Never
  Was it normal or abnormal? (circle one) NORMAL ABNORMAL

- When was the patient's last colonoscopy? (circle one)
  1. Less than 10 years ago 2. More than 10 years ago 3. Never

- Has the patient had a flu shot this season? (circle one) YES / NO

- Has the patient had a pneumococcal vaccine since turning 65 years old? (circle one) YES / NO

- When was the patient's last tetanus shot? (circle one)
  1. Less than 5 years ago 2. 5-10 years ago 3. More than 10 years ago

- Has the patient had shingles vaccine? (circle one) YES / NO

- Has the patient fallen in the past three months? (circle one) YES / NO

- Please circle all the following devices that the patient <u>owns</u>.
  1. Cane 2. Walker 3. Manual Wheelchair 4. Motorized Wheelchair 5. Scooter

- Please circle which of the following devices that the patient <u>uses</u>.
  1. Cane 2. Walker 3. Manual Wheelchair 4. Motorized Wheelchair 5. Scooter

4. PLEASE ANSWER THE FOLLOWING QUESTIONS ABOUT SOCIAL HISTORY

Do you drink alcohol? _____ Yes, occasionally _____ Yes, daily _____ No
How Much? _____

Do you smoke? _____ Yes _____ No _____ Smoked in the past _____ Spouse smoked
How many packs per day? ____ How many years ago did you quit? _____

Do you have any children? _____ No _____ Yes # daughters _____ #sons _____

What is your Marital Status?
_____ Married _____ Single _____ Widowed _____ Divorced

Where do you currently live?
_____ Private Home _____ Assisted Living Facility _____ Retirement Facility

What was your former occupation? _____

Do you have any of the following documents? (Please check all that apply)

_____ Living Will

_____ Do Not Resuscitate (DNR) form for Texas

_____ Designation of a person who has medical Power of Attorney in case you become incapacitated

_____ Advance Directive to Physicians

5. ARE YOU CURRENTLY EXPERIENCING ANY OF THE FOLLOWING?
PLEASE ANSWER "Yes" or "NO" TO ALL QUESTIONS.

Symptom	Y	N
Fever		
Weight loss		
Weight gain		
Loss of Appetite		
Weakness		
Fatigue		
Runny nose		
Cough		
Itchy/watery eyes		
Nasal congestion		
Post-nasal drip		
Rash		
Sneezing		
Sore Throat		
Open wound		
Bruising		
Decubitus ulcer		
Itching		
Mole (growth or change)		
Hearing Loss		
Toothache		
Nosebleeds		

Symptom	Y	N
Fainting		
Chest pain		
Shortness of breath		
Palpitations		
Dizziness		
Leg edema (swelling)		
Gas		
Fecal incontinence		
Black stools		
Abdominal pain		
Nausea		
Vomiting		
Heartburn		
Difficulty swallowing		
Diarrhea		
Constipation		
Blood in stool		
Hemorrhoids		
Neck pain		
Joint pain		
Joint stiffness		
Joint swelling		

Symptom	Y	N
Back pain		
Body aches		
Leg cramps		
Catheter (bladder)		
Difficulty initiating urination		
Burning or pain with urination		
Urinary frequency		
Urinary urgency		
Blood in urine		
Urinary incontinence		
Urinating at night		
Headache		

Symptom	Y	N
Paralysis/weakness		
Tingling/numbness		
Speech abnormality		
Visual changes		
Memory loss/ confusion		
Seizures		
Difficulty walking		
Sleep problems		
Depression		
Anxiety		
Paranoia		
Hallucinations		
Valvular Heart Disease		

6. ARE YOU ABLE TO PERFORM THE FOLLOWING ON YOUR OWN?

	Y	N
Bathing		
Dressing		
Grooming		
Feeding		

	Y	N
Driving		
Toileting		
Transfers		
(getting in & out of chair or bed)		

7. PLEASE LIST ANY OTHER DOCTORS OR SPECIALISTS THAT YOU CURRENTLY SEE.

NAME	CITY	STATE	PHONE	FAX

8. PLEASE LIST FORMER PRIMARY CARE PHYSICAN

Name:_____

Address:_____

City/State/Zip:_____

Phone:_____

Fax:_____

9. WHICH HOSPITAL DO YOU PREFER TO USE?

O Baylor-Grapevine O Harris HEB

O North Hills Hospital O Other _____

10. WHICH PHARMACY DO YOU PREFER TO USE FOR URGENT PRESCRIPTIONS?

Name:_____

Address:_____

Phone:_____

Fax:_____

11. PLEASE LIST YOUR MAIL-ORDER PHARMACY, IF APPLICABLE.

Name:_____

Address:_____

City/State/Zip:_____

Phone:_____

Fax:_____