Patient Name: _____

ST JOHN PROVIDENCE HEALTH SYSTEM | NEWLAND MEDICAL ASSOCIATES
St. John Hospital & Medical Center

New Patient Health Questionnaire

Date of Visit ___/___/___ Date of Birth___/___/___ Age _____ Email _____

Race: ☐ Non-Hispanic ☐ Hispanic **Preferred Language:** ☐ English ☐ Other_____

Do you have advanced directives: living will, power of attorney for health care? ☐ Yes ☐ No
Would you like more information on advanced directives? ☐ Yes ☐ No

Name, Address and Phone Number of your Local Pharmacy_____
_____

Do you use a "Mail-in" pharmacy? ☐ Yes ☐ No If yes, please provide the Name, Address and Phone Number
_____

PHYSICIAN INFORMATION: **List all doctors involved in your care (doctors you wish us to communicate with)**			
Specialty	**Doctor Name /Address**	**Phone**	**Fax**
Primary Care/ Internist			
Radiation Oncologist			
Surgeon			
Infectious Disease			
Other			

VISIT INFORMATION (Why have you come to see the doctor?)
What is your Diagnosis?
Date of your Diagnosis? Hospital:
Have you had Genetic testing? ☐ Yes ☐ No If yes, what type?
Reason for your visit: (Describe briefly how your illness started, how it was diagnosed, and what has happened up to now.)
What do you wish to get from today's visit? ☐ Consult ☐ 2nd Opinion ☐ Treatment/follow-up

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ALLERGIES (List medications/food/environmental)	**□ No Allergies**
Allergy	**Describe Reaction**

***Bring all your Medicines in their Original Bottle to your Appointment.**

MEDICATIONS (List all medications including vitamins, hormones, and over-the-counter-medications)				
Medication	**Start Date**	**Dose**	**How often**	**Reason**

PAIN SCALE
If you currently have **pain,** please rate your pain and **circle** a number on the scale that best describes your pain. **0 1 2 3 4 5 6 7 8 9 10** **(No Pain) (Moderate Pain) (Most severe pain)**
Location of pain:
Circle the word that best describes your pain: **Sharp dull aching burning tingling cramping**
Are you taking medicine for your pain? □ Yes □ No If yes, what medicines:
Does the medicine help your pain? □ Yes □ No

DISTRESS SCALE (Distress can mean anxiety, tension, sadness or depression)
If you currently have **distress,** please rate your distress and **circle** a number on the scale that best describes your distress. **0 1 2 3 4 5 6 7 8 9 10** **(No Distress) (Moderate Distress) (Most severe distress)** What is causing you the most distress? □ Cancer related issues □ Financial □ Family □ Other:_____ **Are you interested in learning about available emotional support? □Yes □No □ Maybe**

HISTORY OF SURGERY OR OTHER PROCEDURES		
Date	**Surgery/Procedures**	**Hospital**
Do you have a defibrillator or pacemaker? □ Yes □ No		

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PAST MEDICAL HISTORY: (Please check all that apply.)	**Date of Diagnosis**		**Date of Diagnosis**
Other cancers (list)			
Kidney disease		Gynecological problems What:	
Bladder disease			
Diabetes		Prostate problems	
Heart Disease		Thyroid disease	
High blood pressure		Epilepsy/Seizures	
High Cholesterol		Stroke	
Asthma		Blood clots/bleeding problem	
Lung disease		Arthritis	
Liver disease		Anxiety	
Stomach/Bowel problems		Depression	
Acid reflux (heartburn)		Other problems: Describe:	
Other problems: Describe			

SOCIAL HISTORY
Marital Status: □ Single □ Married □ Divorced □ Widowed
Are you employed □ Yes □ No □ Retired □ Disabled Occupation:
With whom do you live? □ Live alone Is there anything else about you or your situation that we should know?
Do you have children? □ Yes □ No List ages:
Your activity level is: □ Sedentary □ Daily Activities □ Regular Exercise
Do you smoke? □ Yes □ No If Yes, please circle: cigars, cigarettes, pipe, use chewing tobacco Number of Years _____ Number of packs per day: _____ Did you smoke in the past? □ Yes □ No When did you quit? ___/___/___ Are you interested in information about smoking cessation? □ Yes □ No
Do you drink alcohol? □ Yes □ No □ Occasionally Number of days/week: _____ Number of drinks/day: _____ If you used to drink, when did you stop? ___/___/___
Do you use other recreational drugs? □ Yes □ No What drugs? _____ Were you ever exposed to radiation, toxic chemicals, fumes or extensive sun? □ Yes □ No If yes, what: place and date of exposure:
Do you have any special needs related to Religious/Cultural/Spiritual beliefs? □ Yes □ No If yes, please explain:

FAMILY HISTORY: Please list any cancers, blood diseases or major illnesses your family members have had. **(M) = Maternal (P) = Paternal**

Family Member	**Living Status**	**Medical Problem**	**Family Member**	**Living Status**	**Medical Problem**
Mother	□ Living □ Deceased		Grandmother (P)	□ Living □ Deceased	
Father	□ Living □ Deceased		Grandfather (P)	□ Living □ Deceased	
Children	□ Living □ Deceased		Aunt(s)	□ Living □ Deceased	
Brother(s)	□ Living □ Deceased		Uncle(s)	□ Living □ Deceased	

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Sister(s)	□ Living □ Deceased		Cousin(s)	□ Living □ Deceased	
Grandmother (m)	□ Living □ Deceased		Other:	□ Living □ Deceased	
Grandfather (m)	□ Living □ Deceased		Other	□ Living □ Deceased	

GYNECOLOGICAL/OBSTETRIC HISTORY – Women Only	
Age that your period started:	Date of last period: Age when periods stopped (menopause):
Number of pregnancies: Number of children:	Age at first full term pregnancy: _____
Have you had a hysterectomy? □ Yes □ No	Were your ovaries removed? □ Yes □ No
Do/did you use birth control pills? □ Yes □ No	How long? Year stopped?
Do/did you use estrogen/hormone replacement therapy? □ Yes □ No	How long? Year stopped?

Health Maintenance		
Men and Women:		
Have you had a /colonoscopy/sigmoidoscopy?	□ Yes, Date _____	□ No
Have you had a flu vaccination?	□ Yes, Date _____	□ No
Have you had a pneumonia vaccination?	□ Yes, Date _____	□ No
Last Bone Density (DEXA scan)	□ Yes, Date _____	□ No
Women only:		
Do you have regular (yearly) mammograms?		
Do you have regular PAP tests?	□ Yes, Date _____	□ No
Men only:		
Do you examine your own testicles?	□ Yes, Date _____	□ No
Do you have regular prostate exams?	□ Yes, Date _____	□ No

REVIEW OF SYSTEMS – Please check if you have had these symptoms in the **last week**.

	Yes	No		Yes	No		Yes	No
CONSTITUTIONAL			**RESPIRATORY**			**INTEGUMENTARY**		
Fever			Shortness of Breath			Rash		
Chills			Chest Pain			Skin or Mole Changes		
Night Sweats			Cough			Itchy Skin		
Fatigue			Wheezing			**NEUROLOGIC**		
Weight loss			**CARDIOVASCULAR**			Headaches		
EYES			Pounding Heart			Blurred Vision		
Double vision			Ankle Swelling			Numbness/Tingling		
Eye pain			**GASTROINTESTINAL**			Dizziness		
Dry eyes			Nausea/Vomiting			**PSYCHIATRIC**		
ENMT			Diarrhea			Insomnia		
Hearing problems			Constipation			Anxiety		
Sore throat			Rectal Bleeding			Depression		
Sinus drainage/runny nose			Heartburn			Mood Swings		
Mouth sores			**GENITOURINARY**					
Hoarseness			Blood in Urine					
Difficulty Swallowing			Painful Urination					

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	Yes	No		Yes	No		Yes	No
HEME/LYMPHATIC			Frequent Urination					
Easy Bruising			Prostate Problems					
Bleeding Problem			**MUSCULOSKELETAL**					
Swollen or Tender Glands			Joint/Muscle Pain					
BREASTS			Swollen Joints					
Breast masses			Leg Cramps					
Nipple Discharge								