Ascension
St. John Hospital
NEWLAND MEDICAL ASSOCIATES

New Patient Health Questionnaire

Date of Visit ___/___/___ **Date of Birth**___/___/___ **Age** _____ **Email** _____

Ethnicity: 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

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

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	
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: of children:		Age at first full term pregnancy: _____ Number		
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					
	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								