Midwestern University Multispecialty Clinic New Patient Questionnaire

Patient Name_____ Date _____ DOB_____

MEDICAL HISTORY

Have you (patient) ever had or been diagnosed with any of the following? Please circle all that apply

Birth defects or Genetic disorder:	**Gastrointestinal(Stomach/Intestine/Digestion)**	**Neurologic (Brain & Nerves):**
Cerebral palsy, Down's syndrome, deformed kidney, Ehlers-Danlos syndrome, Heart defect, Marfan syndrome, Other: _____	Acid reflux, GERD or Ulcers	Brain tumor
	Bowel obstruction	Dementia or Alzheimer's disease
	Diverticulitis or Diverticulosis	Frequent Fainting
General:	Colon polyps	Guillian-Barre syndrome
Feet, legs or hands swelling (Edema)	Crohn's, Ulcerative Colitis, Celiac, Gluten sensitive, Irritable bowel syndrome—IBS,	Migraines or daily headaches
Chronic Fatigue syndrome		Multiple sclerosis
Insomnia	Liver cirrhosis or Hepatitis--A B C alcohol	Myasthenia gravis
Motor vehicle accidents	Pancreatitis	Nerve damage (Neuropathy)
Vitamin Deficiency	**Genitourinary (Urine & Sexual):**	Paralysis (Bell's Palsy, Polio, Stroke)
Head/Eyes/Ears/Nose/Throat:	Kidney stones	Parkinson's disease
Allergies (environmental)	Kidney dysfunction, failure or dialysis	Seizures or epilepsy
Deafness or hearing loss, (with ringing?)	Polycystic kidneys	Spinal cord injury
Eye disorders: Cataracts, Glaucoma, Macular degeneration	Prostate problem—(enlarged, inflamed)	Stroke (CVA) or mini stroke (TIA)
	Erectile dysfunction (men's impotence)	**Endocrine (Metabolism & Hormones):**
Sjogren's syndrome	Urinary Leaking	Cushing's syndrome or Addison's disease
Pulmonary (Breathing):	Menstrual (female) disorders—(endometriosis, fibroids, infertility, 3 or more miscarriages, polycystic ovaries)	Diabetes
Asthma		Thyroid problem--too high or fast, too low or slow, too big (goiter), nodules (bumps), Grave's, Hashimoto's
COPD / chronic bronchitis / emphysema / pulmonary fibrosis	**Musculoskeletal (Muscles/Bones/Joints):**	
Pulmonary edema	Broken bones _____	
Sleep apnea	Carpal tunnel syndrome	**Infection History:**
Cardiovascular (Heart, Arteries, Veins):	Gout	Measles, Rubella (German Measles), Mumps, Chicken Pox, Meningitis, Polio, Scarlet fever, Cold sores, Heart Infection, Hepatitis, HIV or AIDS, Chlamydia, Gonorrhea, Pelvic inflammatory disease—PID, Herpes, Trichomonas, Syphilis, Tuberculosis, Lyme disease, Rocky Mountain Spotted Fever (RMSF), Valley Fever, Sepsis
Aneurism of artery	Paget's disease	
Bleeding or blood clotting disorder--(DVT, PE)	Temporomandibular joint syndrome (TMJ)	
Chronic Anemia (low red blood cells)	Thin bones (Osteopenia or osteoporosis)	
Sickle cell anemia, trait or disease	**Chronic Pain** _____	
High blood pressure	Arthritis (including rheumatoid)	
High cholesterol	Fibromyalgia	
Heart Attack	Lupus (Systemic Lupus Erythematosis--SLE)	
Heart disease (other)—(Atrial fibrillation, heart failure, murmur, valve) _____	**Cancer** _____	Pneumonia more than 3 times
	Leukemia or lymphoma	Strep throat more than 5 times
Mood Problems:	Melanoma	Kidney or urine infection more than 5 times
Depression, Anxiety, Panic attacks, Bipolar (Manic Depression), Obsessive compulsive disorder (OCD)	**Skin:**	**Other:**
	Eczema, Psoriasis, Rosacea	

MEDICATIONS

Please list all medications, vitamins and herbal supplements you take, including doses, frequency. Also include medicines only taken as needed

ALLERGIES

Please list any medications to which you are allergic or have side effects:

Medication	Reaction	Medication	Reaction

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Do you have any non-medication allergies (insect stings, foods, pets, latex, etc)? Please list: _____

SURGICAL HISTORY

What surgeries have you had? Any serious injuries? Please circle all that apply, and provide the year of occurrence.

Surgery	Year	Surgery	Year
Head/Eyes/Ears/Nose/Throat:		**Gastrointestinal (Stomach/Intestine) & Abdomen**	
Brain surgery		Appendix removed	
Ear tubes placed, removed		Colon or intestinal surgery	
Eye surgery		Gallbladder removed	
Sinus surgery		Hemorrhoids removed	
Thyroid removed		Hernia repair	
Tonsils or adenoids removed		Weight loss surgery	
Cardiovascular (Heart, Arteries, Veins):		**Genitourinary (Urine & Sex Organs):**	
Artery surgery		Bladder surgery	
Dialysis shunt or vein port placed and/or removed		Cesarean section	
Heart surgery		Circumcision as an adult	
Pacemaker insertion or removal		Dilation & curettage of uterus (D & C)	
Varicose vein surgery		Kidney surgery	
Pulmonary (Breathing):		Prostate surgery	
Chest surgery		Tubes tied or ESSURE	
Lung surgery		Uterus surgery	
Breast:		Vasectomy (male sterilization)	
Breast reduction or enlargement		**Other & Injuries:**	
Breast lump removed		Major motor vehicle accident	
Breast removed		Biopsy: What site?	
Musculoskeletal (Muscles/Bones/Joints):		Blood transfusions: Why?	
Broken bone surgical repair		Cosmetic surgery: what kind?	
Foot surgery		Infection surgically removed	
Hand surgery		Organ transplant: which organ?	
Joint surgery		Radiation for cancer	
Spine surgery			

SOCIAL HISTORY

Do you **smoke**? Y N (includes cigar, pipe)	Did you ever? Y N	Age when started	Age when quit	Packs / cigars / pipes per day	Would you like to quit? Y N
Do you use **chewing tobacco**? Y N	Did you ever? Y N	Age when started	Age when quit	Cans per day	Would you like to quit? Y N
Do you drink **alcohol**? Y N	Did you ever? Y N	Age when started	Age when quit	Days per week Drinks per day	Would you like to quit? Y N
Have you used any kinds of **drugs**? Y N	Did you ever? Y N	What have you tried?		EVER used any kind of IV drugs? Y N	Date of last use?

Have you ever considered cutting down drinking or drug use? Y N ; Has anyone ever suggested you cut down or stop drinking or using? Y N
Has drinking alcohol or using any substance gotten you into legal trouble? Y N ; Have you been through rehab? Y N

Marital Status

Single Committed/Engaged Married Separated Divorced Widowed

Living With

spouse/significant other children mother father brothers sisters friends/roommates

How many children do you have? _____

Do you have any pets? What kind? How many? _____

_____

Activity & Lifestyle

Occupation _____

Does your job require you to: Carry Walk Run Stand Lift Climb Sit

How many times per week do you **exercise** (not including work)?_____

Hobbies, activities & interests: _____

_____

Do you work with animals? What kind? _____

_____

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FAMILY HISTORY

Please list health problems of your family members.

Health Problem	Mother	Father	Brother (B) or Sister (S)	Son (S) or Daughter (D)	Grandparent
Allergies (specify—seasonal, food, medicine?)					
Alzheimer's, Dementia, Parkinson's					
Arthritis					
Asthma					
Birth Defects (what kind?)					
Bleeding or Clotting Disorder					
Cancer (what kind?)					
Diabetes (type 1 or 2?)					
Epilepsy or Seizures					
Eye Problems: Glaucoma, Macular Degeneration, Cataracts, Retina Problems					
Gout					
Heart Attack or Bypass Surgery					
Other Heart Disease					
Immune Problem (lupus, UC, RA, etc?)					
Kidney Disease					
Lung Disease					
Mental Illness or Mood Disorder					
Migraines					
Osteopenia or osteoporosis					
Skin Disorders					
Stomach or Intestinal Problems (what kind?)					
Stroke (CVA) or mini stroke (TIA)					
Substance Abuse (alcohol or drugs?)					
Thyroid Disorder					
Tuberculosis					
Other					
Other					

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REVIEW OF SYSTEMS:

ARE YOU CURRENTLY HAVING ANY PROBLEMS RELATING TO THE FOLLOWING AREAS?

General: NO CONCERNS
☐ fatigue ☐ weakness ☐ weight changes ☐ loss of appetite ☐ feeling ill ☐ difficulty sleeping
Other/Explain:_____

Head/Eyes/Ears/Nose/Throat: NO CONCERNS
☐ headache ☐ hearing loss ☐ blurry vision ☐ sinus problems ☐ swollen glands
Other/Explain:_____

Pulmonary (Breathing): NO CONCERNS
☐ shortness of breath ☐ chronic cough ☐ asthma attack
Other/Explain:_____

Cardiovascular (Heart, Arteries, Veins): NO CONCERNS
☐ cold feet ☐ calf cramping with exercise ☐ calf cramping at rest ☐ varicose veins ☐ leg swelling ☐ leg sores
Other/Explain:_____

Gastrointestinal (Stomach/Intestine/Digestion): NO CONCERNS
☐ nausea ☐ vomiting ☐ diarrhea ☐ constipation ☐ heartburn ☐ blood in stool
Other/Explain:_____

Genitourinary (Urine & Sexual): NO CONCERNS
☐ bladder infections ☐ frequent urination
Other/Explain:_____

Musculoskeletal (Muscles/Bones/Joints): NO CONCERNS
☐ low back pain ☐ hip pain ☐ knee pain ☐ ankle pain ☐ foot pain ☐ achey joints ☐ morning foot pain ☐ joint stiffness
Other/Explain_____

Neurologic (Brain & Nerves): NO CONCERNS
☐ numbness in feet ☐ tingling ☐ burning pain ☐ shooting pain ☐ dizziness ☐ loss of sensation
Other/Explain_____

Dermatologic (Skin): NO CONCERNS
☐ dry skin ☐ itchy skin ☐ open wounds ☐ rash ☐ strange mole ☐ thick scarring after surgery ☐ thick nails ☐ ingrown nails ☐ discolored nails Other/Explain_____

Endocrine (Metabolism & Hormones): NO CONCERNS
☐ increased thirst ☐ increased hunger ☐ cold or heat intolerance ☐ past menopause
Other/Explain:_____

Psychology (Mood, Mental): NO CONCERNS
☐ mood changes ☐ thoughts of suicide
Other/Explain:_____

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Patient Name_____ Date _____ DOB_____

WHAT IS YOUR SHOE SIZE? _____

CURRENT PROBLEM

WHAT SPECIFIC PROBLEM BRINGS YOU TO OUR OFFICE TODAY? _____

WHERE IS THE PAIN/PROBLEM LOCATED? _____

HOW LONG AGO DID THIS PROBLEM FIRST START? _____ DAYS / WEEKS / MONTHS / YEARS

DID YOUR PAIN OR PROBLEM: (PLEASE CIRCLE) BEGIN SUDDENLY OR GRADUALLY DEVELOP OVER TIME

HOW WOULD YOU DESCRIBE YOUR PAIN? (PLEASE CIRCLE)
NO PAIN SHARP DULL ACHING BURNING RADIATING ITCHING STABBING OTHER _____

HOW WOULD YOU RATE YOUR PAIN ON A SCALE FROM 0 TO 10? (PLEASE CIRCLE)
(NO PAIN) 0 1 2 3 4 5 6 7 8 9 10 *(WORST PAIN POSSIBLE)*

SINCE THE TIME YOUR PAIN OR PROBLEM BEGAN, HAS IT: (PLEASE CIRCLE) STAYED THE SAME BECOME WORSE IMPROVED

WHAT MAKES YOUR PAIN OR PROBLEM FEEL WORSE? WALKING STANDING DAILY ACTIVITIES RESTING DRESS SHOES HIGH HEELS FLAT SHOES
ANY CLOSED TOE SHOE RUNNING OTHER _____

WHAT MAKES YOUR PAIN OR PROBLEM FEEL BETTER? _____

WHAT TREATMENTS HAVE YOU HAD FOR THIS PROBLEM? _____

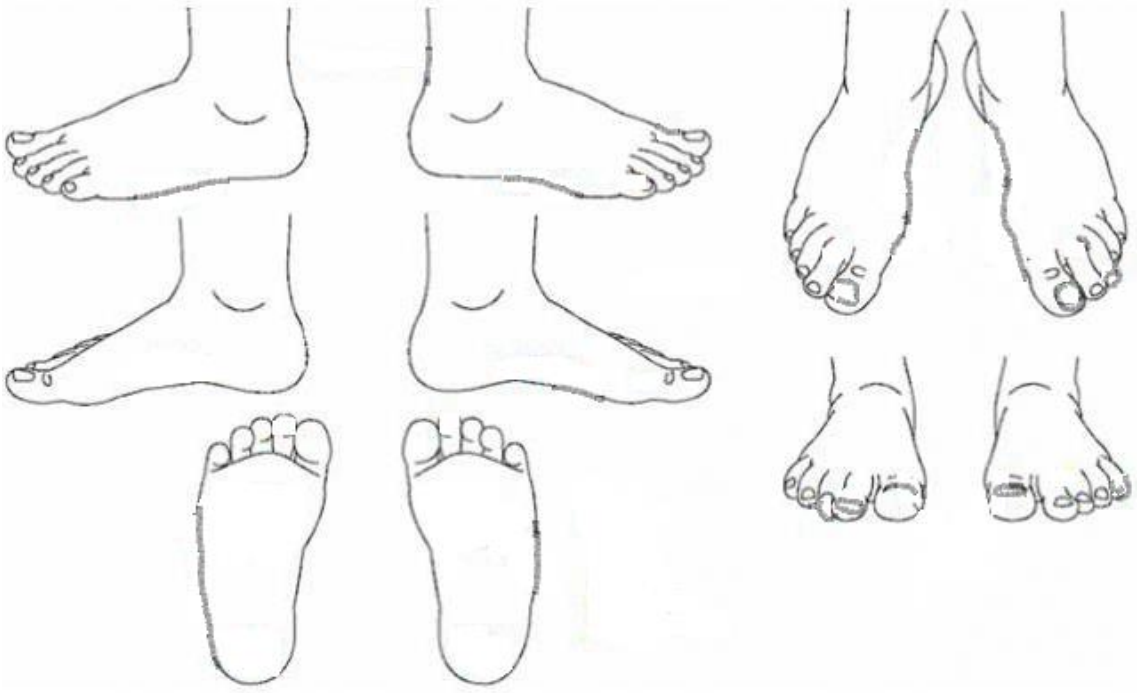
HOW HAS THIS PROBLEM AFFECTED YOUR LIFESTYLE OR ABILITY TO WORK? _____

WAS THIS PROBLEM CAUSED BY AN INJURY? NO YES (DESCRIBE) _____

IF YES, WAS IT A WORK-RELATED INJURY? NO YES

Please mark the areas of pain or discomfort on the chart below, using the appropriate symbols

Numbness	Aching	Pins & Needles	Burning	Stabbing
- - - - - -	o o o o o	^ ^ ^ ^	x x x x	⊗ ⊗ ⊗ ⊗
- - - - - -	o o o o o	^ ^ ^ ^	x x x x	⊗ ⊗ ⊗ ⊗



Midwestern University Multispecialty Clinic New Patient Questionnaire

Patient Name_____ Date _____ DOB_____

Nutrition

Do you follow any particular diet?

_____

Caffeine (coffee, tea, soda): If soda, regular or diet? _____
How many ounces per cup? _____ How many cups per day?
_____

Sleep Patterns

Hours nightly: _____ Good ____ Moderate ____ Poor ____

Have you ever had any form of manipulative treatment?
Osteopathic Y N Chiropractic Y N Other
_____

Women Only

What age did you start menstruating?

_____

First day of last menstrual period:

_____

Are cycles regular? Y N; Length of Cycle?

_____

Length of flow? _____
Do you have heavy cramping? Y N; Heavy flow? Y N;
Number of: Pregnancies _____, Live births _____
Miscarriages _____, Terminations _____, Stillborn
_____

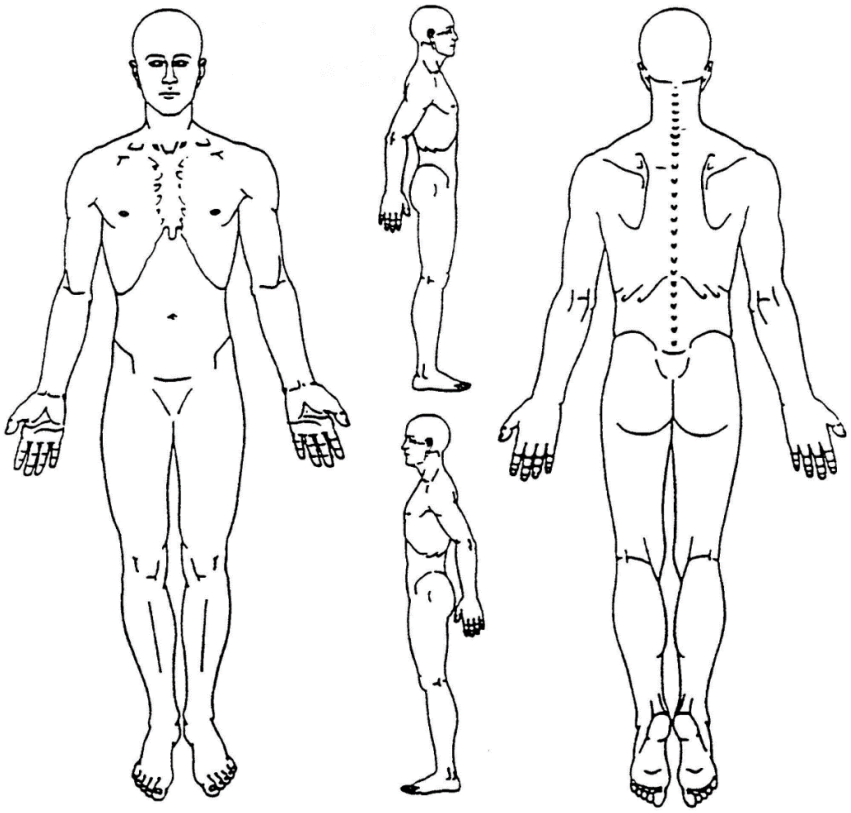
Birth control method:

_____

Pain Diagram

Please mark the areas of pain or discomfort on the chart below, using the appropriate symbols

Numbness	Aching	Pins & Needles	Burning	Stabbing
- - - - - -	o o o o o	^ ^ ^ ^	x x x x	⊗ ⊗ ⊗ ⊗
- - - - - -	o o o o o	^ ^ ^ ^	x x x x	⊗ ⊗ ⊗ ⊗



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Patient Name_____ Date _____ DOB_____

LIVING WILL

Do you have an Advance Directive (Living Will)? _____ If so, does this office have a copy? _____ If not, would you like information about Advance Directives? _____

Daily Living

Do you feel safe at home? Y N
Are you able to do your own bathing and dressing? Y N
Do you use devices such as a walker, cane, wheelchair, or oxygen? Y N
Do you require assistance to perform other household functions? Y N
Do you take care of another adult in your or their home? Y N

Nutrition

Do you follow any particular diet?
_____
Caffeine (coffee, tea, soda): If soda, regular or diet? _____ How many ounces per cup? _____ How many cups per day? _____

Military Service

None Currently active duty Currently reserve/guard Past
Branch? USA USAF USCG USMC USN from_____ to_____
(From all of us here at MWU MSC, thank you.)

Do you now, or have you ever seen any specialists? Y N

TYPE OF SPECIALIST	CITY	DOCTOR'S NAME

When was your last:

Physical _____
EKG _____
Chest X-ray _____
Bone Scan _____
Labwork _____
Colonoscopy_____

Immunizations:

Tetanus _____
Pneumonia vaccine_____
Pneuimonia polyvalent? _____
Flu vaccine_____
Zostavax (shingles vaccine age 60+)_____
Gardisil (HPV vaccine age 9-26) _____

Sleep Patterns

Hours nightly: _____ Good ____ Moderate ____ Poor ____

Have you ever had any form of manipulative treatment?

Osteopathic Y N Chiropractic Y N Other
_____

Women Only

What age did you start menstruating?
_____
First day of last menstrual period:
_____
Are cycles regular? Y N; Length of Cycle?
_____
Length of flow? _____
Do you have heavy cramping? Y N; Heavy flow? Y N;
Number of: Pregnancies _____, Live births _____
Miscarriages _____, Terminations _____, Stillborn _____
Birth control method:
_____

By giving us as much detail as possible, you are helping us to give you the best possible care. Thank you for your patience.