Richmond University Medical Center

An Affiliate of The Mount Sinai Health Network

NEW PATIENT MEDICAL HISTORY QUESTIONNAIRE

Name: _____

Date of Birth _____ **Race**_____

Address (City/State/Zip) _____

Home Phone: _____ **Cell** _____

Please check the box if you have had any of the following problems - currently or in the past:

- ☐ Acid Reflux
- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma or Emphysema
- ☐ Bladder or Kidney Infections
- ☐ Blood Clots/Bleeding Disorders
- ☐ Chronic Diarrhea
- ☐ Diverticulosis
- ☐ Diabetes: If yes, at what age? ____
- ☐ Emotional Problems
- ☐ Epilepsy or Seizures
- ☐ Gall Stones /Gallbladder Disease
- ☐ Gout
- ☐ Heart Disease
- ☐ High Blood Cholesterol
- ☐ High Blood Pressure
- ☐ Kidney Disease/Stones
- ☐ Liver Disease/Hepatitis
- ☐ Lung Disease/Pneumonia
- ☐ Pancreatitis
- ☐ Polyps
- ☐ Rheumatic Fever
- ☐ Skin Disease
- ☐ Sleep Apnea
- ☐ Stroke
- ☐ Venereal Disease/*Syphilis*
  Gonorrhea/Chlamydia
- ☐ Thyroid Disease /Goiter
- ☐ Tuberculosis
- ☐ Tumors/Cancer
- ☐ Ulcers

If **Yes** to any of the above please explain: _____

_____

Review of Current Symptoms – Indicate if you have any of the following problems **NOW:**

Check any/all that apply and explain:

- ☐ Severe or unusual headaches _____
- ☐ Hearing Problems _____
- ☐ Vision Problems _____
  (Other than nearsightedness or farsightedness)
- ☐ Sinus problems or Hay fever _____
- ☐ Hoarseness _____
- ☐ Problem with teeth or gums _____
- ☐ Severe Skin Problems _____
- ☐ Weight loss or gain _____
- ☐ Chest pains or discomfort _____
- ☐ Shortness of breath _____
- ☐ Cough or Phelgm_____ _____
- ☐ Stomach Problems (pain,nausea,vomiting)_____
- ☐ Diarrhea or constipation _____
- ☐ Blood in bowel movements /black bowel movements _____
- ☐ Difficulty or pain on urinating or blood in urine_____
- ☐ Painful Joints_____
- ☐ Sexual difficulties, depression, severe sleep problems, severe stress_____

Please list your CURRENT MEDICATIONS and doses (including medications /supplements not needing a prescription)

Medication	**Dose**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Please list any ALLERGIES OR REACTIONS to medications: _____

_____

_____

SURGICAL HISTORY: **If you have had any surgeries please list:**

Type of Operation	**Hospital**	**Date of Operation**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Dietary/Exercise History

Current Weight _____

Heaviest Weight_____ **Date**_____

Lightest Weight_____

Please list any diets/weight loss programs that you have participated in:

Type of Diet/weight loss program	**Amount of weight lost**	**Date**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Social/Personal History

1. Do you smoke? If yes:

How many years have you smoked? _____

How many packs a day do you smoke? _____

How soon after you awaken do you smoke your first cigarette? ☐ <30mintues ☐ >30minutes

If no:

Have you ever smoked?_____

How many years did you smoke? _____

How many packs per day did you smoke? _____

When did you quit smoking? _____

2. **Do you drink alcohol?** ☐ YES ☐ NO

If no: Have you in the past? ☐ YES ☐ NO

If yes: Specify frequency and quantity _____

On days when you had a drink about how many drinks (beer, wine, or liquor did you have)?_____drinks

3. **Recreational drugs?** ☐ YES ☐ NO If yes, please specify _____

For female patients:

Age of 1st menstrual period _____ Last menstrual period_____ Date of last pap smear_____

Number of pregnancies _____ Number of miscarriages _____Number of live births_____C-sections_____

Are you currently pregnant? ☐ Yes ☐ No Do you have any history of breast or ovarian cancer? _____

FAMILY HISTORY: Please list any history of diabetes, heart disease, cancer, high blood pressure and who in your family had it: _____

_____

_____

_____

_____

_____