# Questionnaire for New Patient (MISC)

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Your name: ____________________________________________ Age: _____ Today's date:_________

Who is your primary care physician? _________________________________

When did you last see him/her? _______________________________

BODY PART INJURED: _______________________________

Please mark an **X** below to indicate which applies to you:

**Past** Medical History:
Have you ever had any of the following **in the past**?

__ Asthma
__ Balance problems
__ Bladder or Urinary Infections
__ Blood in stools
__ Blood Clots
__ Cancer (Type: _______________)
__ Chest Pain
__ Chronic Bronchitis
__ Cramping in leg while walking
__ Colitis
__ Deep Vein Thrombosis
__ Diabetes
__ Dizziness
__ Emphysema
__ Fainting
__ Frequent bloody nose or gums
__ Gallstones
__ Heart Attack
__ Heart murmur
__ Heart surgery
__ High blood pressure
__ High cholesterol
__ Joint replacement
__ Kidney Stones
__ Osteoporosis
__ Poor circulation
__ Recurrent infections
__ Shortness of breath
__ Slowly healing wounds
__ Stomach ulcer

___ NORMAL, I've had none of the above

Review of Systems:
Do you **currently** have any of the following? ___ NORMAL- I have none of the following

__ Reaction to NSAIDS/anti-inflammatory medications (i.e. Advil, Ibuprofen, Naproxen, Celebrex, etc…)
__ Fever or chills
__ Recent weight gain or loss
__ Changes in vision: sensitivity to light, blurred, or double vision
__ Change in hearing, bloody noses, sore throat, cough
__ Shortness of breath, coughing of blood, wheezing, coughing of blood
__ Palpitations, light headedness, dizziness
__ Loss of appetite, weight loss, pain with swallowing, nausea, vomiting, abdominal pain or bloating, blood in your stools, diarrhea, constipation
__ Difficulty urinating, pain with urination, blood in urine
__ Rashes, insect bites, new skin lesions

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What medications do you take?

1. ________________________________
2. ________________________________
3. ________________________________
4. ________________________________

Are you allergic to any medications?

___ NO- no known drug reactions or allergies
___ YES: _____________________

Do you smoke?

__ NO
__ Yes
If yes, how much?___________
Packs per day: ________
Cigarettes per day: ________
Socially

How much alcohol do you drink? __________

__ None
___ Drinks per day/week? _________
___ Socially

What surgeries have you had in the past? (please indicate body part)

1. ________________________________
2. ________________________________
3. ________________________________
4. ________________________________

Patient Signature ________________________________

Parent/ Guardian Signature (if minor) ______________________________________

Thank you,

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