APEX INTERNAL MEDICINE

New Patient Health Questionnaire

Please fill out all sections completely

Today's Date:_____

Patient Name: _____ **Date of Birth**: _____ **Age**: _____

Previous Primary Care Physician (if any): _____

Address:_____

Other Physicians involved in your care:

1. _____
2. _____
3. _____

Specialty:

_____

_____

__

_____

_

Reason for visit today:

1. _____
2. _____
3. _____

MEDICATION Allergies: □ **None**

Medication name:	Reaction:
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____

Food Allergy: □ **None** □ Peanut □ Shellfish

Medication List: (Please list name/dose/frequency if known)
(example: Lipitor 10mg 1 tablet at bedtime, Metformin 500mg twice a day)

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____
11. _____
12. _____
13. _____
14. _____

Vitamins and Herbal Supplements:

□ **None** □ St John's Wart □ Vitamin D _____mg/day

□ Iron _____mg/day □ Folic Acid ____mg/day □ Thiamine ____mg/day

Family History: (please indicate deceased or alive, medical issues and age)

Father: □ Alive (Age ___) □ Deceased (Age ___)
Cause of death: _____
Medical History: _____
Mother: □ Alive (Age ___) □ Deceased (Age ___)
Cause of death: _____
Medical History: _____
Siblings:
1. Sister/Brother □ Alive (Age ___) □ Deceased (Age ___)
Cause of death: _____
Medical History: _____
2. Sister/Brother □ Alive (Age ___) □ Deceased (Age ___)
Cause of death: _____
Medical History: _____
3. Sister/Brother □ Alive (Age ___) □ Deceased (Age ___)
Cause of death: _____
Medical History: _____

Social:

Alcohol: □ None □ Yes: _____ drinks _____ days per week/month What kind _____
(Number) (Number) (Circle one)

Tobacco: □ Never □ Former □ Current Type: □ Smoke □ Vape □ Chew □ Snuff
Amount: _____ per day/week Age started: _____ Age stopped: _____
(Number) (Circle one)

Recreational Substances: □ Never □ Former □ Current If yes, what kind _____

Caffeine: □ None □ Yes: What kind_____ How many/day _____

Water intake: _____ ounces per day

Do you exercise? □ Yes □ No (This does **not** include any occupational activity)
If yes, how much? _____

Social History:

Work: □ Employed □ Unemployed □ Retired □ Disabled
Current Occupation _____ Former Occupation _____
Marital Status: □ Married □ Single □ Divorced □ Domestic Partner
Sexual preference: □ Men □ Women □ Both
Children (age):_____
Hobbies:_____

Immunization History:

Flu: □ Decline □ Yes Last received _____
Shingles (60 or older): □ Decline □ No □ Yes Received _____
Pneumonia (65 or older): □ Decline □ No □ Yes Received PCV13 _____ Received PPSV23 _____
Tetanus (Td or Tdap): □ Decline □ No □ Yes Received _____
Hepatitis C screening (Only answer if born between 1945 through 1965): □ No □ Yes

Past Medical History:

Stroke	□ Yes □ No
Seizures	□ Yes □ No
Diabetes (Type 1 or Type 2)	□ Yes □ No
Thyroid Disease (Low or High)	□ Yes □ No
Glaucoma	□ Yes □ No
High Blood Pressure	□ Yes □ No
Blood Clots	□ No
□ Pulm Emboli (lung clots)	□ Yes □ No
□ DVT (leg clots)	□ Yes □ No
Heartburn, Reflux	□ Yes □ No
Stomach Ulcers	□ Yes □ No
Heart Disease	□ No
□ Coronary Disease	□ Yes □ No
□ MI/heart attacks	□ Yes □ No
□ Congestive Heart Failure	□ Yes □ No
□ Atrial Fibrillation	□ Yes □ No
□ Angina	□ Yes □ No
□ Valve Disorder	□ Yes □ No
High Cholesterol	□ Yes □ No
Gastrointestinal Bleeding	□ Yes □ No
Hepatitis (A, B, C)	□ Yes □ No
HIV / AIDS	□ Yes □ No
Chronic Wounds	□ Yes □ No
Cancer (type)	□ Yes □ No
Incontinence	□ No
□ Urine	□ Yes □ No
□ Stool	□ Yes □ No
Kidney Stones	□ Yes □ No
Sleep Apnea	□ Yes □ No
□ BIPAP	
□ CPAP	
□ No Treatment	
COPD (Emphysema, Bronchitis)	□ Yes □ No
Asthma	□ Yes □ No
Depression	□ Yes □ No
Bipolar Disorder	□ Yes □ No
Anxiety	□ Yes □ No
Gout	□ Yes □ No
Osteoporosis	□ Yes □ No
Prostate Disease	□ Yes □ No
Breast Disease	□ Yes □ No
Erectile Dysfunction	□ Yes □ No

Other_____

Past Surgical History (indicate date if known) :

□ None

□ Tonsillectomy	_____	□ Tubal Ligation	_____
□ Thyroidectomy	_____	□ Hysterectomy (Partial/Complete)	_____
□ Appendectomy	_____	□ Oophorectomy	_____
□ Cholecystectomy	_____	□ C-section	_____
□ Cardiac Stents	_____	□ Prostate Surgery/Bypass	_____
□ Pacemaker	_____	□ Hemorrhoidectomy	_____
□ Heart Bypass|Valve(s)	_____	□ Hernia	_____
□ Spine Surgery	_____	□ Bariatric Surgery	_____
□ Orthopedic/Joint Surgery	_____	□ Bowel/Stomach Resection	_____

□ Other _____

Review of Systems:

Constitutional/Endocrine

	Today	In last 6 months
Fever	□ Yes	□ Yes
Chills	□ Yes	□ Yes
Weakness/Fatigue	□ Yes	□ Yes
Weight Loss/Gain	□ Yes	□ Yes
Insomnia	□ Yes	□ Yes
Snoring	□ Yes	□ Yes
Excessive Thirst	□ Yes	□ Yes
Excessive Urination	□ Yes	□ Yes
Cold/Heat Intolerance	□ Yes	□ Yes

HEENT

	Today	In last 6 months
Sore Throat	□ Yes	□ Yes
Stiff Neck	□ Yes	□ Yes
Change in your voice	□ Yes	□ Yes
Sinus Drainage	□ Yes	□ Yes
Nose Bleeds	□ Yes	□ Yes
Hearing Loss	□ Yes	□ Yes
Ringing in ears	□ Yes	□ Yes
Blurred Vision/Loss	□ Yes	□ Yes
Wear glasses/contacts	□ Yes	□ Yes
Itchy/watery eyes	□ Yes	□ Yes
Dentures	□ Yes	□ Yes
Dental problems	□ Yes	□ Yes

Continued →

Gastrointestinal

	Today	In last 6 months
Nausea /Vomiting	□ Yes	□ Yes
Difficulty swallowing	□ Yes	□ Yes
Hemorrhoids	□ Yes	□ Yes
Diarrhea/ Constipation	□ Yes	□ Yes
Frequent use of Laxatives	□ Yes	□ Yes
Bloody or Black Stools	□ Yes	□ Yes
Abdominal pain	□ Yes	□ Yes
Heart burn/indigestion	□ Yes	□ Yes

Urinary

	Today	In last 6 months
Pain/Burning	□ Yes	□ Yes
Urinary frequency	□ Yes	□ Yes
Urinary Urgency	□ Yes	□ Yes
Blood in urine / Dark urine	□ Yes	□ Yes
Incontinence	□ Yes	□ Yes
Slow starting or stopping urine	□ Yes	□ Yes

Genital/Sex Organs

	Today	In last 6 months
Penile discharge	□ Yes	□ Yes
Testicular lump/pain	□ Yes	□ Yes
Breast Pain/discharge/lump	□ Yes	□ Yes
Painful intercourse	□ Yes	□ Yes
Lack of sexual desire	□ Yes	□ Yes
Functional intercourse problems	□ Yes	□ Yes

FEMALE Reproductive

Age at onset of menstruation_____
1st day of last menstruation_____
Last pap smear: _____
Results: _____
History of abnormal pap: _____

	Today	In last 6 months
Hot Flashes	□ Yes	□ Yes
Postmenopausal Bleeding	□ Yes	□ Yes
Excessive menses	□ Yes	□ Yes
Unusual vaginal discharge	□ Yes	□ Yes
Menstrual pain/cramps	□ Yes	□ Yes
Spotting between periods	□ Yes	□ Yes

Total Pregnancies: _____
Total live births: _____
Total miscarriages: _____
Total abortions: _____
Total C-sections: _____

Cardiac

	Today	In last 6 months
Chest pain	□ Yes	□ Yes
Palpitations	□ Yes	□ Yes
Irregular heartbeat	□ Yes	□ Yes
Exercise intolerance	□ Yes	□ Yes
Leg swelling	□ Yes	□ Yes

Respiratory

	Today	In last 6 months
Persistent Cough	□ Yes	□ Yes
Coughing up blood	□ Yes	□ Yes
Shortness of breath	□ Yes	□ Yes
Wheezing	□ Yes	□ Yes
Can't breathe lying flat	□ Yes	□ Yes

Skin

	Today	In last 6 months
Rashes/Hives	□ Yes	□ Yes
Skin discoloration	□ Yes	□ Yes
Lesions/moles/warts	□ Yes	□ Yes
Ulcers	□ Yes	□ Yes
Itching	□ Yes	□ Yes
Nail Problems	□ Yes	□ Yes
Unusual Hair loss	□ Yes	□ Yes
Easy bruising	□ Yes	□ Yes

Psych

	Today	In last 6 months
Depressed mood	□ Yes	□ Yes
Suicidal thoughts/plans	□ Yes	□ Yes
Thoughts of self-harm	□ Yes	□ Yes
Agitation/irritability	□ Yes	□ Yes
Insomnia	□ Yes	□ Yes
Anxiety	□ Yes	□ Yes
Frequent crying spells	□ Yes	□ Yes

Musculoskeletal

	Today	In last 6 months
Joint pain/stiffness/swelling	□ Yes	□ Yes
Muscle weakness	□ Yes	□ Yes
Back pain	□ Yes	□ Yes
Muscle spasms/cramps	□ Yes	□ Yes
Falling	□ Yes	□ Yes

Neurologic

	Today	In last 6 months
Frequent Headache	□ Yes	□ Yes
Seizures	□ Yes	□ Yes
Syncope (passing out)	□ Yes	□ Yes
Limb weakness/numbness	□ Yes	□ Yes
Dizziness	□ Yes	□ Yes
Balance issues	□ Yes	□ Yes
Tremors	□ Yes	□ Yes
Rigidity	□ Yes	□ Yes