UCLA Health System

MRN:
Patient Name:

(Patient Label)

NEW PATIENT QUESTIONNAIRE
INTERNAL MEDICINE

What brings you in today? ______________________________

____

____

Please list all of your medical conditions.

1. ______________ 5. ______________
2. ______________ 6. ______________
3. ______________ 7. ______________
4. ______________ 8. ______________

What surgical or medical procedures have you had in the past?

1. ______________ 4. ______________
2. ______________ 5. ______________
3. ______________ 6. ______________

Please tell us about medical conditions in your family including cancer, diabetes, heart disease, etc.

Mother: ______________________________
Father: ______________________________
Siblings: ______________________________
Others: ______________________________

What medications, herbs, and vitamins/ supplements are you currently taking? Remember to include over-the-counter medicines. Please include the doses and how often you take each one.

1. ______________ 6. ______________
2. ______________ 7. ______________
3. ______________ 8. ______________
4. ______________ 9. ______________
5. ______________ 10. ______________

Social History:

Relationship status: ☐ Married/Partner ☐ Single ☐ Divorced ☐ Widowed

Preferred sexual partner: ☐ Men ☐ Women ☐ Both ☐ Never sexually active

Currently sexually active: ☐ Yes ☐ No

Have you ever been pregnant: ☐ Yes ☐ No How many times? ______________

Do you have children? ☐ Yes ☐ No How many? ______________

Who lives with you at home? ______________________________

Do you feel safe at home and in your current relationship? ☐ Yes ☐ No

What is your occupation? ______________________________

What (if any) physical activity/exercise do you engage in and how often? ______________

____

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Do you drink alcohol? ☐ Yes ☐ No

If yes, how often? _____ drinks per ☐ day ☐ week ☐ month

If yes, how many times in the past year have you had more than 4 alcoholic drinks in one day?
____

Do you smoke? ☐ Now ☐ Past ☐ Never

If so, how many per day and for how long? ______________________________

Have you ever had a blood transfusion? ☐ Yes ☐ No

How often have you noticed the following emotions over the last two weeks: (circle the answer that best describes how you feel)

Little interest in doing things	☐ None	☐ Several days	☐ More than half the days	☐ Nearly every day
Feeling down or depressed	☐ None	☐ Several days	☐ More than half the days	☐ Nearly every day

Review of Systems: Please circle if you are currently having any of the following symptoms.

Constitutional
Fever
Night sweats
Weight loss
Fatigue

Eyes
Blurred vision
Double vision
Eye pain
Eye dryness

Ear/nose/throat
Hearing loss
Ringing in ears
Hoarseness
Trouble swallowing
Sneezing frequently
Runny nose
Snoring
Choking/gasping during sleep

Cardiovascular
Chest pain
Palpitations

Respiratory
Cough
Trouble breathing

Gastrointestinal
Nausea/vomiting
Diarrhea
Constipation
Abdominal pain
Heartburn

Genitourinary
Leaking urine
Burning urination
Blood in urine
Heavy vaginal bleeding

Musculoskeletal
Muscle pain
Muscle twitching/cramping
Joint pain/stiffness
Joint swelling
Gait difficulty
Falls/fear of falling
Back pain

Skin
Rash
Nail changes

Endocrinologic
Excessive thirst
Hot or cold always
Excessive urination

Hematologic
Abnormal bleeding/bruising
Lumps or swelling

Allergic
Frequent infections

Psychiatric
Sad or depressed
Trouble sleeping
Memory problems

Neurologic
Numbness/tingling
Tremors
Headaches
Dizziness

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Health Maintenance/Prevention

Please specify if and when you received the following services.

All patients:

☐ Influenza (flu) vaccine Date __________ ☐ HIV test Date __________

☐ Tetanus vaccine Date __________ ☐ Seen the dentist Date __________

☐ Pertussis vaccine Date __________ ☐ Had your eyes checked Date __________

☐ Hepatitis A vaccine Date __________

☐ Hepatitis B vaccine Date __________

☐ Varicella vaccine Date __________

Over 50:

☐ Pneumonia vaccine Date __________ ☐ Blood in stool cards Date __________

☐ Zostavax vaccine Date __________ ☐ Colonoscopy Date __________

☐ Bone density scan Date __________

Women only:

All:

☐ Pap smear Date __________

Under 27:

☐ HPV/Gardasil vaccine Date __________

☐ Chlamydia (urine) test Date __________

Over 40:

☐ Mammogram Date __________

Men only:

Under 27:

☐ HPV/Gardasil Vaccine Date __________

Over 40:

☐ Abdominal ultrasound Date __________

☐ PSA test Date __________

Patient Signature: ________________________________ **Date:** ______________ **Time:** __________

If signed by anyone other than patient, please specify relation to the patient: ______________

MD signature: __________________________ **Pager/ ID:** __________ **Date:** _____________ **Time:** _________