UCLA Health

NEW PATIENT QUESTIONNAIRE

Title	First Name	Middle	Last Name	Date

Is this your legal name? ○ Yes ○ No

If not, what is your legal name? _____

Were you known by any other names in the past? _____

Marital Status (select one):

○ Married ○ Divorced ○ Legally Separated ○ Widowed
○ Single ○ Significant Other ○ Domestic Partner ○ Other

Occupation: _____

What is your gender? ○ Male ○ Female

Date of birth (MM / DD / YYYY): _____

What is your email? _____ ☐ I do not have an email account.

Who referred you to our office? (Please select one.)

○ UCLA website (urology.ucla.edu or uclahealth.org)
○ Search engine (eg. Google, Bing, etc.)
○ Social media (eg. Facebook, Twitter, etc.)
○ UCLA Health newsletter (Vital Signs, etc.)
○ Outdoor advertising
○ Radio advertising
○ Referred by friend / family
○ Office signage
○ Referred by MD — name of your doctor: _____
○ Referred by insurance plan — insurance plan: _____
○ Other — please explain: _____
○ Online advertising
○ Webinar
○ Other internet
○ Yelp advertisement
○ Newspaper advertising
○ TV (news coverage)
○ Email message

What is the reason for your visit?

_____

_____

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Allergies

Please list any allergies you have below:

Medications

Please list any prescription or over the counter medications (OTC) that you have taken below:

Medication:	Dose:	Directions for Use:	Date Started:	Date Discontinued:

Medical History

Do you now have or have you ever had any of the following?

(please check YES if applicable to each question below.)

Abnormal pap	☐ Yes	Allergies	☐ Yes
Anemia	☐ Yes	Asthma	☐ Yes
Clotting disorder	☐ Yes	Colon polyps	☐ Yes
Chronic obstructive pulmonary disease (COPD)	☐ Yes	Coronary artery disease	☐ Yes
Diabetes mellitus	☐ Yes	HIV / AIDS	☐ Yes
Glaucoma	☐ Yes	Hypertension	☐ Yes
Hormone problems	☐ Yes	Infertility	☐ Yes
Inflammatory bowel disease (IBD)	☐ Yes	Kidney stones	☐ Yes
Kidney disease	☐ Yes	Liver disease	☐ Yes
Peripheral vascular disease (PVD)	☐ Yes	Stroke	☐ Yes
Sexually transmitted diseases (STD)	☐ Yes	Thyroid disease	☐ Yes
Urinary tract infection (UTI)	☐ Yes	Ulcers	☐ Yes
Vaginal infection	☐ Yes		

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Review of systems: Eyes

Do you now have or have you ever had any of the following?
(please check YES if applicable to each question below.)

Blurring of vision	☐ Yes	Double vision	☐ Yes
Trouble seeing far or near objects	☐ Yes	Spots in front of eyes	☐ Yes

Review of systems: ENT

Do you now have or have you ever had any of the following?
(please check YES if applicable to each question below.)

Headaches	☐ Yes	Trouble hearing	☐ Yes
Painful or difficulty swallowing	☐ Yes		

Review of systems: Neurological

Do you now have or have you ever had any of the following?
(please check YES if applicable to each question below.)

Difficulty speaking	☐ Yes	Passing out	☐ Yes
Sudden mental changes	☐ Yes	Unsteady gait	☐ Yes
Numbness or weakness in arm or legs	☐ Yes	Tremors	☐ Yes
Loss of feeling in any area	☐ Yes		

Review of systems: Respiratory

Do you now have or have you ever had any of the following?
(please check YES if applicable to each question below.)

Persistent cough	☐ Yes	Tuberculosis	☐ Yes
Painful breathing	☐ Yes	Emphysema	☐ Yes
Blood in sputum	☐ Yes	Asthma	☐ Yes
Shortness of breath	☐ Yes	Pneumonia	☐ Yes

Review of systems: Gastrointestinal

Do you now have or have you ever had any of the following?
(please check YES if applicable to each question below.)

Weight loss	☐ Yes	Loss of appetite	☐ Yes
Nausea or vomiting	☐ Yes	Bleeding from the rectum	☐ Yes
Abdominal pain or cramps	☐ Yes	Blood in stools	☐ Yes
Frequent need for antacids	☐ Yes	Change in bowel habits	☐ Yes

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Review of systems: Cardiovascular

Do you now have or have you ever had any of the following?
(please check YES if applicable to each question below.)

Heart attack	☐ Yes	Chest pain	☐ Yes
Difficulty breathing at night	☐ Yes	Shoulder pain	☐ Yes
Buttock or calf pain with exertion	☐ Yes	Palpitations	☐ Yes

Review of systems: Genitourinary

Do you now have or have you ever had any of the following?
(please check YES if applicable to each question below.)

Blood in urine	☐ Yes	Leaking of urine	☐ Yes
Burning or pain with urination	☐ Yes	Kidney stones	☐ Yes
Frequent urination	☐ Yes	Difficulty starting stream	☐ Yes
Difficulty emptying bladder	☐ Yes	Walking to urinate	☐ Yes

Review of systems: Integumentary

Do you now have or have you ever had any of the following?
(please check YES if applicable to each question below.)

Breast pain / lump	☐ Yes	Moles and changes	☐ Yes
Nipple discharge	☐ Yes	Sores	☐ Yes
Tumor	☐ Yes	Varicose veins	☐ Yes

Review of systems: Musculoskeletal

Do you now have or have you ever had any of the following?
(please check YES if applicable to each question below.)

Back injury	☐ Yes	Fracture	☐ Yes
Joint pains / stiffness / swelling	☐ Yes	Limitations on walking	☐ Yes
Muscle cramps / pains	☐ Yes	Muscle weakness	☐ Yes

Review of systems: Gynecologic

Do you now have or have you ever had any of the following?
(please check YES if applicable to each question below.)

Menstrual periods	☐ Yes	Pain with intercourse	☐ Yes
Menstrual periods - regular	☐ Yes	Breast swelling or pain	☐ Yes
Menstrual periods - painful	☐ Yes	Breast masses	☐ Yes
Abnormal vaginal bleeding	☐ Yes	Nipple discharge	☐ Yes
Unusual discharge	☐ Yes		

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Past Surgeries / Procedures

Please let us know about any operations you have had in the past by listing them below:
(if you have not had any surgeries / procedures, skip this question.)

Type of surgery / procedure:	Date of surgery: (MM/YYYY)

Past Radiation Therapy Treatment

Please let us know about any radiation therapy treatments you have had in the past by listing them below: (if you have not had any radiation therapy treatments, skip this question.)

Date started (MM / YYYY)	Date stopped (MM/YYYY):	Area of body treated:	Hospital name:	Physician's name:

Major Non-surgical Illness / Hospitalization

Have you ever had a major non-surgical illness that required hospitalization? Please list them below: (if you have never had a non-surgical illness that required hospitalization, skip this question.)

Year: (YYYY)	Type of major illness:	Hospital name:	Physician's name:

Are you receiving any complementary or non-traditional treatments? ○ Yes ○ No

If yes, please list:

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Primary Medical History

Please enter any relevant medical history (e.g. history of kidney stones) or major medical problems:

Family History: Children

Name	Sex	Age	Status (alive/deceased)

Family History

Relationship	Name	Age	Status (alive/deceased)
Mother			
Father			
Sister			
Brother			
Daughter			
Son			
Maternal Aunt			
Maternal Uncle			
Paternal Aunt			
Paternal Uncle			
Maternal Grandmother			
Maternal Grandfather			
Paternal Grandmother			
Paternal Grandfather			

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Family History

Relationship

Conditions: (Please select all that apply)	Mother	Father	Sister	Brother	Daughter	Son	Maternal Aunt	Maternal Uncle	Paternal Aunt	Paternal Uncle	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather
No known diseases														
Alcohol														
Arthritis														
Asthma														
Birth defects														
Cancer														
Breast cancer														
Colon cancer														
Ovarian cancer														
Prostate cancer														
Pancreatic cancer														
COPD														
Depression														
Diabetes														
Drug abuse														
Early death														
Hearing loss														
Heart disease														
Hyperlipidemia														
Hypertension														
Kidney disease														
Learning disabilities														
Mental illness														
Miscarriages														
Stroke														
Vision loss														

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Social History: Tobacco

Are you currently smoking tobacco (example: cigarettes or cigars)? ○ Never ○ Yes ○ No (quit)

If you answered Yes, please answer the following questions:

How many packs per day? _____ per day

Total number of years smoking: _____ years smoking

If you answered No, please answer the following question:

When did you quit smoking (MM / YYYY)? _____

Social History: Smokeless Tobacco

Are you currently using smokeless tobacco (example: chewing tobacco)? ○ Never ○ Yes ○ No (quit)

If you answered Yes, please answer the following questions:

Total number of years using smokeless tobacco: _____ years smoking

If you answered No, please answer the following question:

When did you quit (MM / YYYY)? _____

Social History: Alcohol

Do you drink alcohol (example: beer, wine or liquor)? ○ Yes ○ No

Comments: _____

If you answered Yes, please answer the following questions:

How many drinks per week do you have? _____ per week

Glasses of wine (5 oz): _____ per week

Cans of beer (12 oz): _____ per week

Shots of liquor (1.5 oz): _____ per week

Drinks containing 1.5 oz of alcohol: _____ per week

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Social History: Recreational Drugs

Do you use prescribed / recreational drugs? ○ Yes ○ No

Comments: _____

If you answered Yes, please answer the following questions:
What recreational drugs do you use / have you used? (Check all that apply.)

☐ Amphetamines (speed)	☐ Amyl nitrate (poppers)	☐ Anabolic steroids
☐ Barbiturates (downers)	☐ Benzodiazepines	☐ 'Crack' cocaine
☐ Cocaine	☐ Codeine	☐ Fentanyl
☐ Flunitrazepam	☐ GHB	☐ Hashish
☐ Heroin	☐ Hydrocodone	☐ Hydromorphone (dilaudid)
☐ Ketamine	☐ LSD	☐ MDMA (ecstacy)
☐ Marijuana	☐ Mescaline (peyote)	☐ Methamphetamines
☐ Methaqualone (quaalude)	☐ Methylphenidate (ritalin)	☐ Morphine
☐ Nitrous oxide	☐ Opium	☐ Oxycodone (oxycontin)
☐ PCP	☐ Psilocybin (shroom)	☐ Solvent inhalants (huff)
☐ Other (specify):		

Social History: Sexual Activity

Are you sexually active? ○ Yes ○ No

Comments: _____

If you answered Yes, please answer the following questions:

Partners: ○ Male ○ Female ○ Both

Birth control / protection: ○ Yes ○ No

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If you answered Yes, what kind(s) of birth control do you use?		☐ None
☐ Abstinence	☐ Contraceptive sponge	☐ Diaphragm / cervical cap
☐ Female condom	☐ Female sterilization	☐ Fertility awareness
☐ Hormonal implant	☐ Hormonal injection	☐ Hormonal patch
☐ IUD (hormonal)	☐ IUD (non hormonal)	☐ Male condom
☐ Not reported	☐ Oral contraceptive	☐ Post-menopausal
☐ Pregnant	☐ Rely on female method	☐ Seeking pregnancy
☐ Spermicide only	☐ Vaginal ring	☐ Vasectomy
☐ Withdrawal / coitus interruptus	☐ Other method (specify):	

Social History: Coffee, Tea, and Soda

How many cups of regular coffee, tea, or soda do you drink per day?

○ None ○ 1-2 per day ○ 3-4 per day ○ More than 5 per day

If more than 5, how many? _____

Social History: Exercise

How often do you exercise (include walking, swimming, bicycling, etc.)?

○ Never ○ Less than once a week ○ 1-2 times per week

○ 3-4 times per week ○ 5 or more times per week

Pregnancy

Is there any chance you could be pregnant now? ○ Yes ○ No

How many pregnancies have you had? _____

How many deliveries have you had? _____

How many children have you had? _____

Comments regarding the health of your children: _____

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Patient or Representative Signature: _____ Date: _____ Time: _____

If signed by someone other than the patient, please specify relationship to the patient: _____

Interpreter Signature: _____ ID#: _____ Date: _____ Time: _____

Physician Signature: _____ ID#: _____ Date: _____ Time: _____