UCLA Health System

NEW PATIENT QUESTIONNAIRE
INTERNAL MEDICINE

(Patient Label)

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 _____
- ☐ Tetanus vaccine Date _____
- ☐ Pertussis vaccine Date _____
- ☐ Hepatitis A vaccine Date _____
- ☐ Hepatitis B vaccine Date _____
- ☐ Varicella vaccine Date _____
- ☐ HIV test Date _____
- ☐ Seen the dentist Date _____
- ☐ Had your eyes checked Date _____

Over 50:

- ☐ Pneumonia vaccine Date _____
- ☐ Zostavax vaccine Date _____
- ☐ Bone density scan Date _____
- ☐ Blood in stool cards Date _____
- ☐ Colonoscopy 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:** _____