Health ONE Skyline Primary Care Physician Care℠

New Patient History and Physical Questionnaire

Patient Name: _____ Date of Birth: _____

Section 1: Review of Systems, please check off all the symptoms you have had in the past 4 weeks.

Constitutional:-→	☐ Fever ☐ Chills ☐ Weight gain ☐ Weight loss ☐ Fatigue ☐ Weakness ☐ Night Sweats	Other symptoms/problems: ☐ ☐ ☐ ☐ ☐ ☐	Notes:
Eyes:→	☐ Double vision ☐ Blurred vision ☐ Last Eye Exam:	Other symptoms/problems: ☐ ☐	Notes:
Ears:→	☐ Decreased hearing ☐ Ear pain ☐ Ringing	Other symptoms/problems: ☐ ☐	Notes:
Nose:→	☐ Congestion ☐ Bleeding ☐ Sinus pain ☐ Snoring	Other symptoms/problems: ☐ ☐ ☐	Notes:
Throat/Mouth:→	☐ Pain ☐ Hoarseness ☐ Dental problems ☐ Neck pain	Other symptoms/problems: ☐ ☐ ☐	Notes:
Pulmonary System:→	☐ Cough ☐ Shortness of breath ☐ Stopped breathing during sleep ☐ Dose-off easily during the day	Other symptoms/problems: ☐ ☐ ☐	Notes:
Cardiac System:→	☐ Chest pain ☐ Palpitations ☐ Ankle swelling ☐ Night time urination	Other symptoms/problems: ☐ ☐ ☐	Notes:
Gastrointestinal:→	☐ Indigestion ☐ Heart burn ☐ Abdominal pain ☐ Nausea ☐ Excessive belching ☐ Excessive flatus (gas) ☐ Bloating ☐ Diarrhea ☐ Constipation ☐ Hemorrhoid pain	Other symptoms/problems: ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	Notes:
Urogenital System:→	☐ Urine Frequency ☐ Urine burning ☐ Urgency ☐ Night time urination ☐ Hesitancy ☐ Dribbling ☐ Incontinence ☐ Weak Stream ☐ Discharge (vaginal or penile) ☐ Sores/ulcers ☐ Vaginal Odor ☐ Abnormal bleeding ☐ Sexual problems ☐ Menstrual problems	Other symptoms/problems: ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	Notes:

Health ONE Skyline Primary Care Physician Care℠

New Patient History and Physical Questionnaire

Patient Name: _____ Date of Birth: _____

Musculoskeletal:→	☐ Joint pain ☐ Joint swelling ☐ Joint redness ☐ Joint stiffness ☐ Joint grinding ☐ Muscle stiffness ☐ Muscle weakness ☐ Muscle pain ☐ Morning stiffness	Other symptoms/problems: ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	Notes:
Skin System:→	☐ Rash ☐ Lumps/bumps ☐ Sores ☐ Abnormal moles ☐ Itching	Other symptoms/problems: ☐ ☐ ☐ ☐	Notes:
Neurological:→	☐ Numbness ☐ Weakness ☐ Pain ☐ Headache ☐ Dizziness ☐ Loss of coordination ☐ Loss of balance ☐ Passing out ☐ Tremor	Other symptoms/problems: ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	Notes:
Psychological:-→	☐ Depression ☐ Loss of interest in things you used to enjoy ☐ Decreased motivation ☐ Decreased energy ☐ Agitation ☐ Insomnia ☐ Sleeping too much ☐ Thoughts of dying ☐ Irritable ☐ Crying spells ☐ Decreased appetite ☐ Increased appetite ☐ Hallucinations ☐ Hearing voices ☐ Worry a lot ☐ Anxious ☐ Obsessive or compulsive ☐ Decreased libido/interest in sex	Other symptoms/problems: ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	Notes:
Endocrine:→	☐ If you have Diabetes, are you checking your blood sugars? What are they running? ☐ ☐ Cold intolerant ☐ Heat intolerant ☐ Hot flashes ☐ Thirsty all the time ☐ Urinate a lot ☐ Hungry all the time	Other symptoms/problems: ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	Notes:
Hematological:→	☐ Fatigue ☐ Easy bruising ☐ Excessive bleeding	Other symptoms/problems: ☐ ☐	Notes:

Health ONE Skyline Primary Care Physician Care℠

New Patient History and Physical Questionnaire

Patient Name: _____ Date of Birth: _____

Section 2: Past Medical History, please check off past and present medical problems and surgeries.

Head & Neck Illness:→	☐ Glaucoma ☐ Cataracts; Date of surgery? ☐ ☐ Other eye surgery ☐ Ear surgery ☐ Mastoiditis ☐ Meniere Disease ☐ Inner-ear infection ☐ Chronic sinusitis ☐ Chronic nasal allergies ☐ Nasal polyps ☐ Nose surgery ☐ Dental surgery ☐ Tonsillectomy ☐ Carotid artery surgery	Other illness/problems: ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	Notes:
Pulmonary Illness:→	☐ Asthma ☐ Chronic bronchitis ☐ Emphysema ☐ Interstitial lung disease ☐ Pneumonia ☐ Valley fever ☐ Tuberculosis	Other illness/problems: ☐ ☐ ☐ ☐ ☐ ☐	Notes:
Cardiac Illness:→	☐ Heart attack; when? ☐ Angina (heart pain) ☐ Cardiac stress test ☐ Coronary angiography (heart cath) ☐ Heart bypass surgery; Date? ☐ Other heart surgery ☐ Heart murmur ☐ Heart failure ☐ Hypertension (high blood pressure) ☐ Pericarditis	Other illness/problems: ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	Notes:
Neurological Illness:→	☐ Stroke ☐ TIAs (pre stroke) ☐ Neuropathy ☐ Carpal tunnel syndrome ☐ Multiple Sclerosis ☐ Epilepsy/seizures ☐ Parkinson's Disease ☐ Vitamin B12 deficiency ☐ Migraine headaches ☐ Tension headaches ☐ Cluster headaches ☐ Sinus headaches ☐ Dementia (e.g. Alzheimer's)	Other illness/problems: ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	Notes:
Gastrointestinal: →	☐ Esophagitis/reflux/GERD ☐ Hiatal hernia ☐ Stomach or duodenal ulcer ☐ Gastritis or duodenitis ☐ Colon polyps ☐ Diverticulosis/diverticulitis ☐ Colitis (Chron's or Ulcerative Colitis)	Other illness/problems: ☐ ☐ ☐ ☐ ☐	Notes:

New Patient History and Physical Questionnaire

Patient Name: _____ Date of Birth: _____

Gastrointestinal: → Continued	☐ Giardia ☐ Hemorrhoids, Surgery? ☐ Stomach or bowl surgery ☐ Gall stones/surgery ☐ Pancreatitis ☐ Hepatitis ☐ Jaundice ☐ Spleen problem, Surgery? ☐ Groin hernia, Surgery? ☐ Ventral or umbilical hernia, Surgery? ☐ Appendectomy	☐ ☐ ☐ ☐ ☐	Notes continued:
Breasts: →	☐ Breast Cancer, Surgery? ☐ Fibrocystic breast disease ☐ Breast biopsies ☐ Last mammogram	Other illness/problems: ☐ ☐ ☐	Notes:
Musculoskeletal: →	☐ Osteoarthritis ☐ Rheumatoid Arthritis ☐ Gout ☐ Pseudogout ☐ Lupus ☐ Scleroderma ☐ Fibromyalgia ☐ Joint surgery, Which ones? When? ☐ Broken bones, Which ones? When? ☐ Herniated disc ☐ Other back problems ☐ Raynaud's Disease ☐ Foot problems	Other illness/problems: ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	Notes:
Dermatological: →	☐ Eczema ☐ Psoriasis ☐ Seborrheic dermatitis ☐ Warts ☐ Melanoma (malignant mole) ☐ Basal cell skin cancer ☐ Squamous cell skin cancer ☐ Actinic keratosis (pre-cancer sun damage) ☐ Athlete's foot	Other illness/problems: ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	Notes:
Psychiatric Illness: →	☐ Depression ☐ Anxiety disorder ☐ Panic disorder ☐ Manic depressive or bipolar disorder ☐ Schizophrenia ☐ Obsessive/compulsive disorder	Other illness/problems: ☐ ☐ ☐ ☐ ☐	Notes:
Urogenital Illness: →	☐ Frequent bladder infections ☐ Kidney infection ☐ Kidney stones ☐ Other kidney problems ☐ Incontinence ☐ Bladder surgery ☐ Kidney surgery ☐ Prostate surgery	Other illness/problems: ☐ ☐ ☐ ☐ ☐ ☐	Notes:

New Patient History and Physical Questionnaire

Patient Name: _____ Date of Birth: _____

Urogenital Illness: → Condition	☐ Kidney cancer, Surgery? ☐ Bladder cancer, Surgery? ☐ Prostate cancer, Surgery? ☐ Ovarian cancer, Surgery? ☐ Uterine/endometrial cancer ☐ Hysterectomy, with or w/o ovary removal ☐ Cervical cancer, Surgery? ☐ Genital warts ☐ Herpes genitalia ☐ Gonorrhea ☐ Chlamydia ☐ Syphilis ☐ HIV/AIDS ☐ PMS (premenstrual tension syndrome) ☐ Endometriosis ☐ Impotence ☐ Pregnancy (list dates, child's sex, vaginal delivery or C-section, and complications) ☐ Miscarriages & abortions (list dates and how many weeks) ☐ Menopause (age of onset) ☐ Last pap smear (month & year):	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	Notes continued:
Endocrine Illness: →	☐ Hypothyroid ☐ Hyperthyroid ☐ Diabetes ☐ Menopause ☐ Thyroid surgery	Other illness/problems: ☐ ☐ ☐ ☐	Notes:
Hematology/Lymphatic: →	☐ Anemia ☐ Bleeding disorder ☐ Hypercoagulable disorder ☐ Lymphoma ☐ Hodgkin's disease ☐ Leukemia	Other illness/problems: ☐ ☐ ☐ ☐ ☐	Notes:

Section 3: Social History and Habits

Used to smoke: **Yes/No** ☐ ☐	**How many packs per day?** **How many years did you smoke?** **When did you quit?**
Currently smoke: **Yes/No** ☐ ☐	**How many packs per day?** **How many years have you smoked?**
Used to drink alcohol: **Yes/No** ☐ ☐	**How many days per week?** **When you did drink, how many drinks would you usually drink in one day?** **What would be the most you would drink in one day?** **When did you quit?**
Currently drink alcohol:	**How many days per week?**

Health ONE Skyline Primary Care Physician Care℠

New Patient History and Physical Questionnaire

Patient Name: _____ Date of Birth: _____

Yes/No ☐ ☐	When you do drink, how many drinks do you usually drink in one day? What would be the most you would drink in one day?
Past recreational Drug use Yes/No ☐ ☐	What years? Did you ever inject drugs?
HIV or Hepatitis risk factors (circle all that apply)	Use IV Drugs ☐ Homosexual intercourse ☐ Blood transfusion ☐ Sex with a drug user or prostitute ☐ more than 5 sexual partners since 1968 ☐ Are you interested in getting an HIV blood test? ☐ ☐ Yes/No

Section 3: Continued

Occupation History (list occupations and any chemical exposures):	
Do you have a living will? ☐ ☐ Yes/No	
Do you have a medical power of attorney? ☐ ☐ Yes/No	Who?
Do you have a durable power of attorney? ☐ ☐ Yes/No	Who?
Circle all that apply	Single ☐ Married ☐ Divorced ☐ Widowed ☐ Gay or lesbian ☐
How important is a religious faith to your health?	Not at all ☐ A little ☐ Medium ☐ A Lot ☐

Health Maintenance and Preventative Medicine

When was your last tetanus shot?		
Have you ever had a pneumonia vaccine?	☐ Yes/No ☐	When?
Have you ever had a shingles vaccine?	☐ Yes/No ☐	When?
Have you ever had a colonoscopy?	☐ Yes/No ☐	When?
Have you ever had a bone density test?	☐ Yes/No ☐	When?
Have you ever had a mammogram?	☐ Yes/No ☐	When was your last one?
When was your last PAP test?		
Have you ever had a PSA test?	☐ Yes/No ☐	When?
Do you have any family history of cancer, diabetes or heart disease in your parents, siblings or children?	☐ Yes/No ☐	If so, who and how old were they when they were diagnosed?

Health ONE Skyline Primary Care Physician Care℠

New Patient History and Physical Questionnaire

Patient Name: _____ Date of Birth: _____

Family History, Please check box below for each illness that applies to a family member

Family Members	Alive or Dead	Current age or age of death	Heart Disease	Asthma	Cancer	Type of Cancer	Stroke	High Blood Pressure	High Cholesterol	Diabetes
Father	Dead									
Mother	Dead									
Siblings: (Names)	**Alive or Dead**	**Age**	**Heart Disease**	**Asthma**	**Cancer**	**Type of Cancer**	**Stroke**	**High Blood Pressure**	**High Cholesterol**	**Diabetes**
	Dead									
	Dead									
	Dead									
	Dead									
	Dead									
	Dead									
	Dead									
Children:	**Alive or Dead**	**Age**	**Heart Disease**	**Asthma**	**Cancer**	**Type of Cancer**	**Stroke**	**High Blood Pressure**	**High Cholesterol**	**Diabetes**
	Dead									
	Dead									
	Dead									
	Dead									
	Dead									
	Dead									
	Dead									

Do you have any specific questions or concerns today?

Health ONE Skyline Primary Care Physician Care℠

New Patient History and Physical Questionnaire

Patient Name: _____ Date of Birth: _____

Height: _____ Weight: _____ Reason for today's visit: _____

Do you smoke? **Yes/ No** If yes how many packs per day? _____

Have you ever smoked? **Yes/ No** If yes when did you quit? _____

Do you use alcohol? **Yes/No** If yes how many drinks per week? _____

Do you or have you used the following in the last three months?

Marijuana/Cocaine/ Heroin/ Crack/ Methamphetamine

Are you allergic to any Medications? Yes or No (if yes, please list)

Name of Medication	Type of reaction

Please list current medications below

Name of Medication	Dosage

Previous Surgeries	Date

Have you ever had any of the following? Circle all that apply:

Asthma, Stomach Problems, Bladder Problems, Jaundice- Liver gout, Alcoholism, Kidney Disease ,
Joint Disease, Skin Disease, Stroke, Epilepsy/Seizures, Depression/Anxiety, Thyroid, Blood Clots,
High Blood Pressure, Tuberculosis, Diabetes, Cancer, Lung Disease, Heart Disease, Psychiatric Disorder

Do any of these conditions run in your family? Circle all that apply:

Alcoholism Addiction Joint Disease Stroke
Blood Clots Diabetes Psychiatric Disorder Heart Disease

Pharmacy Information:

Name: _____ Phone Number: _____

Address: _____

How did you hear about us? Website Family/Friend Internet Search

Former or current patient (please provide a name so we can thank them) _____

Physician (Please Specify): _____

Other (Please specify): _____

Signature	Date