UCLA Health

MRN:
Patient Name:

(Patient Label)

COMPREHENSIVE NEW PATIENT QUESTIONNAIRE

What brings you in today? _____

_____

What do you prefer to be called (nickname)? _____

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., and at what age they developed the disease:

Mother: _____ Age: _____

Father: _____ Age: _____

Siblings: _____ Age: _____

Others: _____ Age: _____

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. _____

Allergies? ☐ Yes ☐ No

If "yes", reactions? _____

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? _____

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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? _____

_____

How would you describe your dietary intake? _____

_____

How much alcohol do you drink? _____ per day _____ per week

If yes, how many times in the past month 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: (check 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 check if you are currently having any of the following symptoms.

Constitutional
- ☐ Fever
- ☐ Night sweats
- ☐ Weight loss
- ☐ Fatigue
- ☐ Excessive sleepiness/ Insomnia

Eyes
- ☐ Blurred vision
- ☐ Double vision
- ☐ Eye pain
- ☐ Eye dryness

Respiratory
- ☐ Cough
- ☐ Trouble breathing
- ☐ Frequent Illness

Gastrointestinal
- ☐ Nausea/vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Abdominal pain
- ☐ Heartburn

Skin
- ☐ Rash
- ☐ Nail changes
- ☐ Mole Changes

Endocrinologic
- ☐ Excessive thirst
- ☐ Hot or cold always
- ☐ Excessive urination

Hematologic
- ☐ Abnormal bleeding/bruising
- ☐ Lumps or swelling

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COMPREHENSIVE NEW PATIENT QUESTIONNAIRE

Ear/nose/throat	Genitourinary	Psychiatric
☐ Hearing loss	☐ Leaking urine	☐ Anxiety
☐ Ringing in ears	☐ Trouble urinating	☐ Sad or depressed
☐ Hoarseness	☐ Blood in urine	☐ Trouble sleeping
☐ Trouble swallowing	☐ Heavy vaginal bleeding	☐ Memory problems
☐ Sneezing frequently		☐ Overwhelming
☐ Runny/Stuffy nose	**Musculoskeletal**	☐ Panic attacks
☐ Snoring	☐ Muscle pain or joint pain	
☐ Choking/gasping during sleep	☐ Muscle twitching/cramping	**Neurologic**
	☐ Joint pain/stiffness	☐ Numbness/tingling
Cardiovascular	☐ Joint swelling	☐ Tremors
☐ Chest pain	☐ Trouble walking	☐ Headaches
☐ Palpitations	☐ Falls/fear of falling	☐ Dizziness
	☐ Back pain	☐ Memory loss

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: _____	☐	Last dental exam	Date: _____
☐	Pertussis vaccine	Date: _____	☐	Last eye exam	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: _____
☐	Pertussis vaccine	Date: _____	☐		Date: _____
☐	Bone density scan	Date: _____	☐		Date: _____

Women only:

All:

☐ Pap smear Date: _____

Under 27:

☐ HPV/Gardasil vaccine Date: _____

☐ Chlamydia (urine) test Date: _____

Over 40:

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☐ Mammogram Date: _____

Men only:

Under 27:

☐ HPV/Gardasil Vaccine Date: _____

Over 40:

☐ Abdominal ultrasound Date: _____

☐ PSA test Date: _____

Do you currently see any other physicians?

Physician: _____ Specialty: _____

Physician: _____ Specialty: _____

Physician: _____ Specialty: _____

Physician: _____ Specialty: _____

Physician: _____ Specialty: _____

Are you up to date on:

Tdap (tetanus, pertussis/whooping cough) Date: _____

HPV (Gardasil) Date: _____

Influenza (flu shot) Date: _____

Pneumonia – 23 Date: _____

Pneumonia – 13 Date: _____

Shingles (Zostavax) Date: _____

Are you up to date on the following:

Colonoscopy (colon cancer screening) Date: _____

Bone Density (osteoporosis screen) Date: _____

Mammogram (breast cancer screen) Date: _____

Pap smear (cervical cancer screen) Date: _____

Prostate cancer screen Date: _____

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COMPREHENSIVE NEW PATIENT QUESTIONNAIRE

The information provided in this questionnaire is true and complete to the best of my knowledge. I understand that the accuracy of the information I have provided is important to my physician and my healthcare team in order to develop an individualized care plan for me.

_____ _____ _____
Patient or Representative Signature Date Time

_____ _____
Print Name Relationship to Patient

_____ _____ _____ _____
Interpreter (if applicable) Interpreter ID # Date Time

_____ _____ _____
Physician Signature Date Time