INFECTIOUS DISEASES ASSOCIATES, P.C.
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NEW PATIENT HEALTH QUESTIONAIRE

NAME: _____ **DOB**: _____ ☐MALE / ☐FEMALE

CHIEF COMPLAINT/REASON for VISIT. Please describe nature and duration of symptoms:

PERSONAL MEDICAL HISTORY:

Please list all past or present medical issues:

☐ Diabetes	☐ History of bone infection	☐ Hepatitis
☐ High blood pressure	☐ History of skin infection	☐ Other:
☐ Cancer	☐ MRSA (staph)	_____
☐ Frequent urine infections	☐ HIV/AIDS	__
☐ Tuberculosis	☐ Kidney failure	
☐ CHF	☐ History of pneumonia	

- Please list all past surgical procedures with approximate dates:

- Please list any recent Hospitalizations, ER visits, or Nursing Home stays (dates & reason):

Please list all CURRENT MEDICATIONS including any recent ANTIBIOTICS (or attach copy of list):

Please list all DRUG ALLERGIES along with type of reaction:

LAB DATA:

Please list any recent: lab work, x-rays, CAT scans, MRI, or other recent studies (along with date and place where you had them done):

FAMILY HISTORY:

If any family members have suffered with the below, please check the appropriate box:

☐ Diabetes	☐ Tuberculosis	☐ Thyroid disease
☐ Cancer	☐ HIV/AIDS	☐ Kidney disease
☐ Stroke	☐ Bleeding disorders	☐ Seizure disorder
☐ Heart disease	☐ High cholesterol	☐ Other: _____
☐ Hepatitis	☐ Depression/Anxiety	

SOCIAL HISTORY:

Please Circle your answers:

Marital Status: **Single / Married / Divorced / Widowed**

Occupation:_____

Tobacco use: **Yes / No** If yes, how many packs per day? _____

Alcohol use: **Never / Rare / Occasional / Daily**

Drug use: Do you use any illegal drugs? **Yes / No** If yes, please list _____

Do you currently or have you ever used IV drugs? **Yes / No**

Do you have any pets? **Yes / No** If yes, list all household animals _____

Have you had contact with small children? **Yes / N** If yes, were they sick? **Yes / No**

Have you traveled anywhere recently? **Yes / No** If yes, please list _____

Are you currently sexually active? **Yes / No**

How many people live in your home? _____

Do you spend a lot of time outdoors? **Yes / No**

Have you noted any recent tick, mosquito, or other insect bites? **Yes / No**

Any recent trauma or breaks in the skin? **Yes / No**

Please list any hobbies:_____

REVIEW OF SYSTEMS:

Please check off any of the below which you are experiencing:

Constitutional: ☐Fever ☐Chills ☐Night Sweats ☐Weight Loss ☐Swollen Lymph Nodes

Eyes: ☐Visual changes ☐Pain behind the eye

Ears: ☐Decreased hearing ☐Ringing in ear ☐Ear pain ☐Drainage from ear

Nose: ☐Sinus trouble ☐Hay fever/allergies

Mouth throat: ☐Sore throat ☐Thrush ☐Recent dental work

Cardiac: ☐Chest pain ☐Palpitations ☐Heart murmur ☐Pacemaker ☐Artificial heart valve

Pulmonary: ☐Shortness of breath ☐Coughing ☐Emphysema

GI: ☐Nausea ☐Vomiting ☐Abdominal pain ☐Diarrhea ☐Decrease in appetite

GU: ☐Pain with urination ☐Blood in urine ☐Frequent urinary tract infections ☐Vaginal/penile discharge ☐Urinary frequency ☐History of sexually transmitted disease

Back: ☐New onset back pain ☐Chronic back pain

Musculoskeletal: ☐Joint pain ☐Joint swelling ☐Muscle pain

Hematology: ☐Bruise easily ☐Bleeding disorder ☐History of blood transfusions ☐Anemia

Skin: ☐Rashes ☐Tattoos ☐Psoriasis ☐Itching ☐Piercings ☐Other:_____

Psychology: ☐Depression ☐Anxiety ☐Suicide attempts

Endocrine: ☐Diabetes ☐Hyper/Hypothyroidism

Neurology: ☐History of seizure disorder ☐Strokes ☐Dizziness ☐Lightheadedness ☐Numbness/tingling ☐Leg weakness ☐Headache

Any history of the following: ☐Tuberculosis ☐Herpes/shingles ☐HIV/AIDS ☐Hepatitis B ☐Hepatitis C

If you have a history of: HIV/AIDS, Have you ever suffered from the following?

☐MAI ☐PCP ☐Pneumonia ☐Meningitis ☐Syphilis

Patient Signature_____ Date_____