

Joan and Sanford I. Weill
Medical College

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NEW PATIENT QUESTIONNAIRE

NAME: _____ DATE OF BIRTH: _____

COUNTRY OF BIRTH: _____ OCCUPATION: _____

WITH WHOM DO YOU CURRENTLY RESIDE? _____

DATE OF LAST EXAM BY A PHYSICIAN: _____

NAME OF PHYSICIAN: _____

PLEASE LIST THE OTHER PHYSICIANS WHO SHOULD RECEIVE A COPY OF YOUR MEDICAL RECORDS:

	PHYSICIAN NAME	ADDRESS	FAX	PHONE
1				
2				
3				
4				

KNOWN MEDICATION (DRUG) ALLERGIES: _____

OTHER KNOWN ALLERGIES: _____

CURRENT MEDICATIONS			
	NAME OF MEDICINE	DOSAGE/STRENGTH	HOW MANY PER DAY
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			

If you take more than 10 medications, please continue on the back of this page.

FAMILY HISTORY: Please list the known medical illnesses of your relatives and their current age. If deceased, please indicate the age of death.

1. Paternal Grandfather (Age____): _____
2. Paternal Grandmother (Age____): _____
3. Maternal Grandfather (Age____): _____
4. Maternal Grandmother (Age____): _____
5. Father (Age____): _____
6. Mother (Age____): _____
7. Brother(s) & Age(s): _____
8. Sister(s) & Age(s): _____
9. Son(s) & Age(s): _____
10. Daughter(s) & Age(s): _____

Do any of your blood relatives have any of the following medical illnesses?

- | | | |
|--|--|--|
| <input type="checkbox"/> Sudden Infant Death | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Thyroid Disease or Goiter |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Asthma | <input type="checkbox"/> Mental or Nervous Disorders |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Blood Clotting | |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Gout | |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Bleeding Disorder | |
| <input type="checkbox"/> Stroke | | |
| <input type="checkbox"/> Arthritis | | |

PAST MEDICAL HISTORY:

Date of first and last transfusion, if any? _____

Past Medical Injuries: _____

Past Medical Illnesses (Diagnoses): _____

- | | | | |
|------------------------|--|-----------------|--|
| Measles | <input type="checkbox"/> Yes <input type="checkbox"/> No | Scarlet Fever | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Chickenpox | <input type="checkbox"/> Yes <input type="checkbox"/> No | Diphtheria | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Whooping Cough | <input type="checkbox"/> Yes <input type="checkbox"/> No | Rheumatic Fever | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Mumps | <input type="checkbox"/> Yes <input type="checkbox"/> No | Pneumonia | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Liver Disease/Jaundice | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tuberculosis | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Malaria | <input type="checkbox"/> Yes <input type="checkbox"/> No | Asthma | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Tuberculosis | <input type="checkbox"/> Yes <input type="checkbox"/> No | Other _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Dysentery | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |

HOSPITAL ADMISSIONS			
	NAME OF HOSPITAL	DATE	ILLNESS OR OPERATION
1			
2			
3			
4			
5			
6			

If you have had more than 6 hospitalizations, please continue to list them on the back of this page.

HABITS:

1. How many hours do you usually sleep each night? _____
2. How many hours a day do you work? _____
3. How many days per week do you work? _____
4. Have you ever smoked? _____ How long? _____ packs/day? _____
5. How much alcohol do you consume each week? _____
6. How often do you exercise? _____
7. What kind of exercise do you do? _____
8. How many cups of tea or coffee do you drink each day? _____
9. What type of foods do you eat? _____
10. Describe your diet briefly? _____

Below is a list of questions designed to help you remember symptoms you have had in the past.

1. Have you had any significant infections or diseases of the skin? Yes No
2. Has your skin changed in character or texture recently? Yes No
3. Are you bothered by severe itching? Yes No
4. Do you bruise easily? Yes No
5. Has your hair changed in amount or texture? Yes No
6. Does your hair fall out easily? Yes No
7. Do you perspire excessively? Yes No
8. Do you suffer frequent headaches? Yes No
9. Do you have sick headaches (migraine)? Yes No
10. Do you faint easily? Yes No
11. Have you ever been knocked unconscious? Yes No
12. Do you have lightheadedness or giddiness? Yes No
13. Did you ever have severe dizziness? Yes No
14. Do you wear glasses? Yes No
15. Did you ever see double? Yes No
16. Have you had any loss of vision? Yes No
17. Have you had inflammation of the eyes? Yes No
18. Do you have difficulty distinguishing colors? Yes No
19. Do you have spots before your eyes? Yes No
20. Date of last eye examination: _____
21. Have you had any loss of hearing? Yes No
22. Have you ever had earaches or discharge? Yes No

- | | | | |
|-----|---|------------------------------|-----------------------------|
| 23. | Do you have buzzing or ringing in your ears? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 24. | Have you ever had your ears punctured? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 25. | Do you have frequent colds? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 26. | Do you have excessive nasal discharge? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 27. | Did you ever have frequent or severe nosebleeds? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 28. | Have you had sinus trouble? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 29. | Have you had excessive trouble with your teeth? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 30. | Do your gums bleed frequently? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 31. | Do you wear dentures? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 32. | Is your tongue frequently sore or sensitive? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 33. | Date of last dental check-up _____ | | |
| 34. | Have you had frequent or severe sore throats? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 35. | Have you had tonsillitis? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 36. | Do you have difficulty swallowing? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 37. | Are you subject to hoarseness? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 38. | Have you had swollen or discharging glands in your neck? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 39. | Have you had a goiter? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 40. | Have you had a metabolism test or other thyroid tests done? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 41. | Does cold or hot weather bother you excessively? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 42. | Have you ever been treated for thyroid trouble? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 43. | Have you noticed lumps or nodules in your breasts? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 44. | Have you had a bloody discharge from your breasts? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 45. | Have you had an operation on your breasts? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 46. | Date of last mammogram (women): _____ | | |
| 47. | Do you have a chronic cough? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 48. | Do you raise more than one tablespoon of sputum daily? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 49. | Have you ever coughed up blood? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 50. | Do you have night sweats? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 51. | Have you been told that you had any lung or bronchial trouble? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 52. | Have you had pleurisy? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 53. | Have you noticed a wheeze or whistle in your chest on breathing? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 54. | Have you had close contact with a person who had tuberculosis (TB)? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 55. | Have you had a skin test for TB? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| | If yes, when was it? _____ Was it positive or negative? _____ | | |
| 56. | Have you been told you have heart disease or murmur? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 57. | Have you been told you had high blood pressure? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 58. | Do you become winded on climbing two flights of stairs? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 59. | Do you have pain or a tight feeling in your chest on exertion? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 60. | Do you have to sleep propped up in a bed? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 61. | Do your ankles swell? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 62. | Do you have palpitations (heart beating rapidly)? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 63. | Have you been refused life insurance at normal rates? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 64. | Have you noticed any loss of appetite? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 65. | Do any foods cause indigestion or diarrhea? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 66. | Do you have indigestion or excessive gas? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 67. | Do you have pain to your stomach? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 68. | Have you vomited blood? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 69. | Are you constipated? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 70. | Have your bowel habits changed in the past six months? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

- | | | | |
|------|--|------------------------------|-----------------------------|
| 71. | Do you pass mucous in your stool? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 72. | Do you have hemorrhoids (piles)? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 73. | Have you been jaundiced (yellow eyes and skin)? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 74. | Have you had intestinal worms or parasites? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 75. | Have you lost weight in the past year? If yes, how much? _____ | | |
| 76. | Date of last colonoscopy or sigmoidoscopy: _____ | | |
| 77. | Do you get up every night to urinate? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 78. | Do you have burning pain when you urinate? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 79. | Have you had pus in the kidneys or urine? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 80. | Do you have trouble starting your stream when you urinate? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 81. | Have you passed stones or gravel in the urine? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 82. | Have you passed blood in the urine? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 83. | Have you had albumin in the urine? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 84. | Do you ever lose control of your bladder? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 85. | Has a doctor ever said you had a kidney or bladder disease? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 86. | Have you had sugar in the urine? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 87. | Have you had or suspected you had a venereal disease? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 88. | Did you ever have painful or swollen joints? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 89. | Are you subject to rheumatism? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 90. | Have you ever had trouble with your back? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 91. | Do you have varicose veins? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 92. | Have you ever had phlebitis? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 93. | Do you have pain in your legs when walking? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 94. | Are you subject to dizziness, fainting, twitching, spells or fits? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 95. | Was any part of your body ever paralyzed? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 96. | Do you have shooting pains in your arms or legs? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 97. | Do you have numbness or tingling in your fingers or toes? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 98. | Have you ever consulted a psychiatrist? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 99. | Do you cry easily? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 100. | Do you worry very much? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 101. | Do you regard yourself as being nervous? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 102. | Do you tire very easily? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 103. | Are you depressed and blue much of the time? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 104. | Is it difficult for you to make up your mind? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 105. | Are your feelings easily hurt? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 106. | Are you easily irritated and upset? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 107. | Does every little thing get on your nerves? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 108. | Are you extremely shy or sensitive? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 109. | Do people often annoy or irritate you? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 110. | Are you constantly keyed up and jittery? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 111. | Is your home life unpleasant? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 112. | Is your work unpleasant? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 113. | Do you bite your fingernails? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 114. | Have you ever been hospitalized for psychiatric issues? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

For Men

115. Date of last blood PSA test? _____ PSA Value _____

For Women

- 116. Were you older than 15 when your periods began? Yes No
- 117. Do your periods last more than five days? Yes No
- 118. Does pain with your periods frequently make you lie down? Yes No
- 119. Are you usually tense and jumpy with your periods? Yes No
- 120. Do you have bleeding or discharge between your periods? Yes No
- 121. Do you have hot flashes? Yes No
- 122. What was the first day of your last period? _____

I would like to request an AIDS test (HIV antibody test). Yes No

MEDICAL RECORDS ARE CONFIDENTIAL

I ask that Dr. David Wolf discuss my medical problems with no one .

I authorize Dr. David Wolf to discuss my medical problems with the following people:

I request that I be contacted in the afternoon of the business day prior to my initial consultation appointment by e-mail at _____ or telephone at _____.

Signature: _____ Date: _____