New Patient Health Summary Questionnaire

To be completed by Surfside Personnel

Temp________HR_____ BP_____/_____ RR_____
O2_______% WT_________ HT_________
VA OD_____/20 OS_____/20 OU_____/20
____ corrected ____ pin hole

Patient Name: ____ **Today's Date**_____________

Reason you are being seen today: ____

When did your symptoms begin?: ___________________________________

RECENT SYMPTOMS: **Please circle any symptoms you are having or have had recently.**

CONSTITUTIONAL	APPETITE CHANGE	CHILLS	FATIGUE
	FEVER	SWEATS	WEIGHT LOSS
CARDIOVASCULAR	CHEST PAIN/PRESSURE	FAINTING	PALPITATIONS
NEUROLOGICAL	HEADACHE	LIGHT HEADEDNESS	NUMBNESS
	POOR BALANCE	TINGLING	WEAKNESS
PSYCHIATRIC	ANXIETY/NERVES	DEPRESSION	
LYMPHATIC	FREQUENT INFECTIONS	SWOLLEN GLANDS	
EYES	BLURRED VISION	CONTACT LENSES	DOUBLE VISION
	EYE DISCHARGE	EYE PAIN	EYE GLASSES
ENT	DIZZINESS	EAR PAIN	NASAL CONGESTION
	NOSE DISCHARGE	SNEEZING	SORE THROAT
RESPIRATORY	CONGESTION	COUGH	SHORT OF BREATH
	WHEEZING		
GASTROINTESTINAL	ABDOMINAL PAIN	DIARRHEA	NAUSEA
	RECTAL PROBLEM	BOWEL CHANGES	VOMITING
URINARY	DISCHARGE	FREQUENT URINATION	NIGHTTIME URINATION
	PAINFUL URINATION	SEXUAL DIFFICULTY	
MUSCULAR	JOINT PAIN	MUSCLE PAIN	SWELLING
SKIN	BRUISING	ITCHING	LACERATION
	RASH	REDNESS	SKIN SORES

[ ] None of the above [ ] Additional Problems: ____

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FEMALES:

Last Normal Menstral Period: ___________ **Are You Pregnant?** [ ] yes [ ] No [ ] Unsure

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CURRENT MEDICATIONS: [ ] NONE ____

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CURRENT ALLERGIES: [ ] No Allergies ____

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MEDICAL HISTORY: [ ] No Medical Problems or History

CIRCLE ALL PROBLEMS THAT APPLY:

Arthritis	Heart Problems	Stroke or seizure
Blood Disorder	High Blood Pressure	Psychiatric
Cancer - Type:____________	High Cholesterol	Sexually Transmitted Disease
Diabetes ? Insulin	Kidney Problems	Skin Disorders
Ear, Nose or Throat Problems	LungProblems	Thyroid Problem
Gastrointestinal (stomach)	Liver Problems, Hepatitis	Other:
Genitourinary	Musculoskeletal	

SURGICAL HISTORY: [] No Surgeries ____

SOCIAL HISTORY:

Tobacco Use: [} Never [} Quit: When ________; How long did you smoke?__________

[ ] Current: packs per day_______; For how many years? __________

Alcohol use: [ ] None [ ] Quit [ ] Rare [ ] Occasional [ ] Daily

Recent Travel: [ ] No [ ] Yes: Where? ________________________________

FAMILY HISTORY: [} No Family History [ ] Unknown [ ] Adopted

Please Specify: M=Mother; F=Father; S=Sibling; GP=Grandparent

Heart Disease [M] [F] [S] [GP]	High Cholesterol [M] [F] [S] [GP]
Cancer: type:______________[M] [F] [S] [GP]	High Blood Pressure [M] [F] [S] [GP]
Lung Disease [M] [F] [S] [GP]	Brain Aneurism [M] [F] [S] [GP]
Diabetes [M] [F] [S] [GP]	Alzheimer's [M] [F] [S] [GP]
Psychiatric [M] [F] [S] [GP]	Other: ___________________ [M] [F] [S] [GP]

Preventive (Vaccines): [ ] All Childhood vaccinations Up to Date

Tetanus: [ ] < 5 years [ ] > 5 years Approximate Date: __________

[ ] Influenza/flu shot): Year: ________ [ ] Varicella/Chicken Pox

Additional Notes:____

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