NEW PATIENT HEALTH QUESTIONNAIRE

To be completed by Surfside Personnel

☐ Well-Side ☐ Sick-Side ☐ Outside-Sick

T _____°F HR_____ BP_____/_____ RR_____ O2_____%

Wt:_____lbs. Ht:_____ in.

VA: Rt_____/20 Lt _____/20 B_____/20 ____Corrected ____PH

Patient Name:_____ **Date of Birth:**_____ **Today's Date:**_____

Gender Identity:_____ (Optional) Nickname:_____ (Optional) Pronouns:_____

Reason for visit: (Please check only one or two main concerns)

☐ sinus ☐ ear ☐ fever ☐ sore throat ☐ vomiting/diarrhea
☐ cough /respiratory ☐ covid/flu symptoms ☐ **other**_____

Is this injury related? ☐ Yes ☐ No **If Yes:** Is this a work injury? Yes ☐ No ☐ Is this an auto accident? Yes ☐ No ☐

☐ referral ☐ allergic reaction ☐ foreign body in eye ☐ eye issue ☐ rash ☐ ear clogged ☐ urinary issue ☐ STI Testing
☐ cardiovascular ☐ dizziness ☐ head injury ☐ abdominal pain ☐ genital pain ☐ muscle pain ☐ joint pain ☐ fall/injury
☐ animal bite/scratch ☐ catfish/jellyfish sting ☐ laceration/wound ☐ suture removal ☐ **other**_____

Medications: **(Females: include birth control)** ☐ None ☐ Copy of list given to staff _____

_____

Allergies: ☐ None ☐ Copy of list given to staff _____

Females: **Last Normal Menstrual Period Date:**_____ ☐ No, Menopause:_____ ☐ No, Birth control prevents cycle
Are you pregnant? ☐ Yes ☐ No ☐ Unsure **Are you breast feeding?** ☐ Yes ☐ No

Vaccines: ☐ Childhood vaccines up to date ☐ Covid primary ☐ Covid Booster –Year:_____ ☐ Influenza/Flu –Year:_____
☐ Tetanus less than 5 years –Year:_____ ☐ Tetanus greater than 5 years –Year:_____
☐ Shingles ☐ Chicken Pox/Varicella ☐ Pneumococcal (Optional 65 yr +) –Year:_____

Medical history: **(Please inform us of all diagnosed conditions/diseases you have)** ☐ None ☐ Arthritis ☐ Asthma
☐ COPD ☐ Lung Disease ☐ High Cholesterol ☐ High Blood Pressure ☐ Pacemaker ☐ Heart Disease
☐ Stroke ☐ Seizure ☐ Hyper – Thyroid ☐ Hypo – Thyroid ☐ Skin Disorder:_____
☐ Liver Problem:_____ ☐ Kidney Problem:_____ ☐ Gastrointestinal Problem:_____
☐ Psychiatric:_____ ☐ Diabetic; Type:_____ ☐ Cancer; Type:_____
☐ ENT Problems:_____ ☐ Other:_____ ☐ Other:_____

Major Surgeries: ☐ None _____

Social History: **Tobacco/Vape:** ☐ Never ☐ Quit –Year_____ ☐ Current; Type:_____
Years of use:_____ # of Packs/day_____
Alcohol: ☐ None ☐ Rare ☐ Occasional ☐ Daily # per day_____Type: ☐ Beer ☐ Wine ☐ Liquor
Illegal drug use: ☐ Never ☐ Quit ☐ Current; Type:_____
How often?_____How many years?_____

Recent Travel: **within 2 weeks nationally, 3 months internationally** ☐Yes ☐ No
If Yes: When?_____ Where?_____ Potential Exposure:_____

Family History: **(diagnosed conditions/diseases) Please specify M = Mother F = Father S = Sibling GP = Grandparent**
☐ No change ☐ None ☐ High Cholesterol:_____ ☐ High Blood Pressure:_____ ☐ Heart Disease:_____
☐ Lung Disease:_____ ☐ Cancer:_____ Type:_____ ☐ Diabetes:_____ Type:_____
☐ Other _____

SYMPTOMS: When did symptoms begin?_____ Known exposures?_____

Please check any symptoms you are experiencing or have had recently:

CONSTITUTIONAL	☐ change in appetite	☐ chills	☐ fatigue
	☐ fever	☐ sweats	
CARDIOVASCULAR	☐ chest pain / pressure	☐ fainting	☐ fluttering / palpitations
	☐ leg swelling	☐ low blood pressure	☐ high blood pressure
NEUROLOGICAL	☐ headache	☐ light headedness	☐ loss of consciousness
	☐ numbness / tingling	☐ poor balance	☐ weakness
PSYCHIATRIC	☐ anxiety / nerves	☐ depression	☐ sleep difficulties
LYMP / HEMATOLOGIC	☐ bleeding	☐ bruising	☐ frequent infections
	☐ nodes / glands		
EYES	☐ blurry vision	☐ contact lenses	☐ double vision
	☐ eye discharge	☐ eyeglasses	☐ eye redness
	☐ eye swelling	☐ eye pain	
ENT / MOUTH	☐ change in taste or smell	☐ difficulty swallowing	☐ dizziness
	☐ ear pain	☐ hoarseness	☐ loss of taste or smell
	☐ mouth pain	☐ nasal congestion	☐ nose discharge
	☐ sore throat		
RESPIRATORY	☐ chest congestion	☐ dry cough	☐ shortness of breath
	☐ snoring	☐ wet cough	☐ wheezing
GASTROINTESTINAL	☐ abdominal pain	☐ blood in stool	☐ constipation
	☐ diarrhea	☐ nausea	☐ rectal / perirectal complaints
	☐ bowl changes	☐ vomiting	
GU	☐ blood in urine	☐ discharge / yeast	☐ frequent urination
	☐ nighttime urination	☐ painful urination	☐ itching / burning
	☐ menstrual complaints	☐ possible pregnancy	
MUSCULAR	☐ aches / pains	☐ back pain	☐ joint pain
	☐ muscle pain	☐ swelling	
SKIN	☐ bruised skin	☐ itching / burning pain	☐ laceration
	☐ redness	☐ swelling	☐ skin sores
ENDOCRINE	☐ abnormal blood sugar	☐ cold intolerance	☐ excessive thirst / hunger
	☐ hair loss	☐ heat intolerance	☐ weight loss / gain
ALLERGY / IMMUNE	☐ itchy eyes	☐ lip / tongue / throat swelling	☐ post-nasal drip
	☐ rash	☐ sneezing	

☐ None of the above ☐ Additional Problems:_____

THANK YOU. PLEASE HAND PAPERWORK BACK TO FRONT DESK.