SIERRA CARE PHYSICIANS
A MEDICAL CORPORATION

New Patient
Medical History Questionnaire-Brief

NAME: DOB: DATE:

PLEASE ANSWER BRIEFLY TO THE BEST OF YOUR ABILITY, THANK YOU!

Please include anything from your childhood to the present.

Please check (√)and indicate when

SURGERY? **IF NONE, CHECK HERE: ☐**

- ☐ tonsils
- ☐ hernia
- ☐ colon
- ☐ hysterectomy/uterus
- ☐ prostate
- ☐ colonoscopy
- ☐ appendix
- ☐ gall bladder
- ☐ breast
- ☐ ovaries
- ☐ hemorrhoids
- ☐ thyroid
- ☐ vasectomy or tubal ligation
- ☐ cataract
- ☐ other:_____

MAJOR ILLNESS? **IF NONE, CHECK HERE: ☐**

- ☐ pneumonia
- ☐ stroke
- ☐ diabetes
- ☐ in hospital overnight for any other illness
- ☐ ulcer
- ☐ heart attack
- ☐ asthma
- ☐ other:_____
- ☐ emphysema
- ☐ high blood pressure
- ☐ hepatitis

MAJOR INJURY? **IF NONE, CHECK HERE: ☐**

- ☐ back injury
- ☐ concussion
- ☐ fracture
- ☐ other:_____

SOCIAL HABITS:

- ☐ caffeinated drinks___cups/day ☐ **NONE**
- ☐ smoke/chew___packs/day ☐ **NONE**
- ☐ alcohol___drinks/week ☐ **NONE**

WOMEN:

last pap smear:_____

last mammogram:_____

ALLERGIES?

- ☐ foods:_____
- ☐ medications:_____
- ☐ **IF NONE, CHECK HERE**

LIST ANY MEDICATIONS:

(include routine and any on hand, include non -prescription drugs)

FAMILY HISTORY: Check and indicate which blood relative **IF NONE, CHECK HERE: ☐**

- ☐ cancer
- ☐ heart attack
- ☐ stroke
- ☐ diabetes
- ☐ high blood pressure
- ☐ osteoporosis
- ☐ glaucoma

PLEASE INDICATE THE PROBLEM YOU ARE HERE FOR TODAY:

PLEASE MARK ANY OF THE FOLLOWING SYMPTOMS THAT YOU ARE CURRENTLY EXPERIENCING:

☐ CHILLS	☐ URINARY INCONTINENCE
☐ FATIGUE	☐ JOINT PAIN
☐ FEVER	☐ JOINT STIFFNESS
☐ LOSS OF APPETITE	☐ JOINT SWELLING
☐ BLURRED VISION	☐ MUSCLEACHES
☐ CHANGE IN VISION	☐ HEADACHE
☐ EYE PAIN	☐ TINGLING
☐ EAR PAIN	☐ NUMBNESS
☐ HEARING LOSS	☐ ANXIETY
☐ HOARSENESS	☐ DEPRESSION
☐ CHEST PAIN	☐ DIFFICULTY SLEEPING
☐ LEG SWELLING	☐ EXCESSIVE SWEATING
☐ PALPITATIONS	☐ EXCESSIVE THIRST
☐ COUGH	☐ FEELING COLD
☐ PHLEGM	☐ HAIR CHANGES
☐ SHORTNESS OF BREATH	☐ NEW/CHANGING SKIN LESIONS
☐ WHEEZING	☐ RASH
☐ ABDOMINAL PAIN	☐ EASY BRUISING
☐ CONSTIPATION	☐ SLOW HEALING
☐ DIARRHEA	☐ RECURRENT INFECTIONS
☐ HEARTBURN	☐ SWOLLEN GLANDS
☐ BURNING WITH URINATION	