Sparrow Medical Group

New Patient Questionnaire

(Please print clearly and fill out entirely)

Name_____ SSN# _____

Former/Maiden Name _____ Preferred Name _____

Date of Birth _____ Age_____ Gender_____

Address _____

_____

Preferred Phone _____ Alternate Phone_____

Email Address _____

If Minor, name and phone number of Parents/Guardian

_____

_____

Employer _____ Occupation _____

Retirement status _____ Date of Retirement _____

*Preferred Language _____Need Interpreter_____

Marital Status _____ Religion _____

Race _____ Ethnicity _____

Emergency Contact, relationship to Patient, and phone. (please include spouse/significant other if applicable and at least one individual outside the home)

_____

_____

Advance Directives

*Do you have a Durable Medical Power of Attorney? (please circle) Yes No
If yes, a copy is requested for your medical record.

If no, would you like an information packet today? (please circle) Yes No

Please have all insurance cards and information available each time you check in.

**Questions are required by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). Thank You.*

Name _____ Date of Birth _____ Today's Date _____

Allergies Please list all allergies and types of reactions (including medication, latex, foods, iodine, peanuts, eggs, shellfish etc.)

Allergy	**Reaction**

Medications Please list all current medications (including vitamins, herbs, supplements and over-the-counter medications.)

Name of medication	**Dose**	**Amount taken**	**How often**	**Prescribed by**
Ex: Vitamin D	*1,000 IU*	*1 tablet*	*Once daily*	*Dr. Smith, Cardiologist*

Personal Medical History Do you have or have you had any of the following?

Allergies	Yes	No	Depression	Yes	No	Meningitis	Yes	No
Anemia	Yes	No	Diabetes	Yes	No	Heart Attach (MI)	Yes	No
Anxiety	Yes	No	Emphysema	Yes	No	Nerve/Muscle Disorder	Yes	No
Arthritis	Yes	No	GERD (Reflux)	Yes	No	Osteoporosis	Yes	No
Asthma	Yes	No	GI Ulcers	Yes	No	Seizures	Yes	No
Blood Transfusions	Yes	No	Glaucoma	Yes	No	Sickle Cell Anemia	Yes	No
Cancer	Yes	No	Heart Murmur	Yes	No	Stroke	Yes	No
Cataracts	Yes	No	HIV/AIDS	Yes	No	Substance Abuse	Yes	No
Congestive Heart Failure	Yes	No	High Cholesterol	Yes	No	Thyroid Disease	Yes	No
Clotting Disorder	Yes	No	High Blood Pressure	Yes	No	Tuberculosis	Yes	No
COPD	Yes	No	Kidney Disease	Yes	No			

Name _____ Date of Birth _____ Today's date _____

Other past medical history not listed or important details we should know?

Surgical History

Appendectomy	Yes	No	Cosmetic Surgery	Yes	No	Joint Replacement	Yes	No
Brain Surgery	Yes	No	C-section	Yes	No	Prostate Surgery	Yes	No
Breast Surgery	Yes	No	Eye Surgery	Yes	No	Small Intestine Surgery	Yes	No
CABG (Heart Bypass)	Yes	No	Fracture Surgery	Yes	No	Spine/Back Surgery	Yes	No
Cholecystectomy (Gallbladder out)	Yes	No	Hernia Repair	Yes	No	Tubal Ligation	Yes	No
Colon Surgery	Yes	No	Hysterectomy	Yes	No	Valve Replacement	Yes	No
						Vasectomy	Yes	No
Other Surgical History not listed or important details we should know?								

Personal and Social History Please tell us about yourself. This information is intended to help us understand and meet your care needs.

Do you drink alcohol Yes No	**If yes, type**	**Number per week**
	Glasses of Wine	
	Cans/Bottles of Beer	
	Shots of Liquor	
	Other "drinks"	
Date of last Pap Smear (female)	**Date of last Colonoscopy** Completed where?	**Date of last Bone Mineral Density Test**
Date of last Mammogram Completed where?		**Date of last Eye Exam**
Are you sexually active Yes No	**Partners** Male Female	**Method of birth control**
Number of pregnancies	**Number of births**	
Drug use Yes No	**Past history of drug use** Yes No	**If yes, explain**

Name _____ Date of Birth _____ Today's date _____

Types Marijuana Methamphetamine Cocaine IV Prescription Meds Other:	
Do you use tobacco Yes No Never Quit (date)	
Packs per day ¼ ½ 1 1 ½ 2 3+	**Years smoked**
Do you use smokeless tobacco Yes No Never	**Second hand smoke exposure** Yes No

Family History

Relationship	Status Living/Deceased	Adopted Yes/No	Age	Health Problems	Cause of Death
Mother					
Father					
Sister					
Brother					
Son					
Daughter					
Maternal Grandmother					
Maternal Grandfather					
Paternal Grandmother					
Paternal Grandfather					

Review of Systems

Are you in need of community resources (Support Group, Exercise/Wellness, Food/Housing, Financial Assistance?)	Yes	No
If yes, please list resources needed		

Over the last 3 months, have you been consistently bothered by any of the following symptoms?

General

Activity Change	Yes	No	Excessive Sweats	Yes	No	Unexpected Weight Change	Yes	No
Appetite Change	Yes	No	Fatigue	Yes	No		Yes	No
Chills	Yes	No	Fever	Yes	No		Yes	No

Name _____ Date of Birth _____ Today's date _____

Ears, Nose, and Throat

Congestion	Yes	No	Hearing Loss	Yes	No	Sinus Pressure	Yes	No
Dental Problems	Yes	No	Mouth Sores	Yes	No	Sneezing	Yes	No
Drooling	Yes	No	Nosebleeds	Yes	No	Sore Throat	Yes	No
Ear Discharge	Yes	No	Postnasal Drip	Yes	No	Ringing in Ear	Yes	No
Ear Pain	Yes	No	Runny Nose	Yes	No	Trouble Swallowing	Yes	No
Facial Swelling	Yes	No	Sinus Pain	Yes	No	Voice Change	Yes	No

Eyes

Eye Discharge	Yes	No	Eye Pain	Yes	No	Light Sensitivity	Yes	No
Eye Itching	Yes	No	Eye Redness	Yes	No	Vision Changes	Yes	No

Lungs

Stop Breathing	Yes	No	Cough	Yes	No	Wheezing	Yes	No
Chest Tightness	Yes	No	Shortness of Breath	Yes	No			
Choking	Yes	No	Noisy Breathing	Yes	No			

Heart

Chest Pain	Yes	No	Leg Swelling	Yes	No	Palpitations	Yes	No

Gastrointestinal

Distended (bloated) Abdomen	Yes	No	Bloody Stools	Yes	No	Nausea	Yes	No
Abdominal Pain	Yes	No	Constipation	Yes	No	Rectal Pain	Yes	No
Anal Bleeding	Yes	No	Diarrhea	Yes	No	Vomiting	Yes	No

Endocrinology

Cold Intolerance	Yes	No	Extreme Thirst	Yes	No	Extreme Urination	Yes	No
Heat Intolerance	Yes	No	Extreme Hunger	Yes	No		Yes	No

Genitourinary (GU)

Difficulty Urinating	Yes	No	Flank (side) Pain	Yes	No	Blood in Urine	Yes	No
Painful Urination	Yes	No	Frequent Urination	Yes	No	Urinary Urgency	Yes	No
Incontinence	Yes	No	Genital Sores	Yes	No	Decreased Urination	Yes	No

Gynecology (Women Specific)

Painful Intercourse	Yes	No	Pelvic Pain	Yes	No	Unusual vaginal discharge	Yes	No
Menstrual Problems	Yes	No	Unusal Vaginal Bleeding	Yes	No	Vaginal Pain	Yes	No

Gynecology (Men Specific)

Penile Discharge	Yes	No	Penile Swelling	Yes	No	Testicular Pain	Yes	No
Penile Pain	Yes	No	Scrotal Swelling	Yes	No			

Name _____ Date of Birth _____ Today's date _____

Musculoskeletal

Joint Pain	Yes	No	Walking Problems	Yes	No	Muscle Spasms	Yes	No
Back Pain	Yes	No	Joint Swelling	Yes	No	Neck Pain/Stiffness	Yes	No

Skin

Color/Pigment Changes	Yes	No	Rash	Yes	No	Wounds	Yes	No
Abnormal Paleness	Yes	No						

Allergies

Enviromental	Yes	No	Food	Yes	No	Immunocompromised	Yes	No

Neurological

Dizziness	Yes	No	Numbness or Tingling	Yes	No	Tremors	Yes	No
Facial Drooping	Yes	No	Seizures	Yes	No	Weakness	Yes	No
Headaches	Yes	No	Speech Problems	Yes	No			
Lightheadedness	Yes	No	Loss of Consciousness					

Blood Disorders

Enlarged Lymph Nodes	Yes	No	Easy Bleeding/Bruising	Yes	No			

Behavioral

Agitation	Yes	No	Depression	Yes	No	Self Injury	Yes	No
Behaviorial Problems	Yes	No	Hallucinations	Yes	No	Sleep Disturbance	Yes	No
Confusion	Yes	No	Hyperactive	Yes	No	Suicidal Ideas	Yes	No
Decreased Concentration	Yes	No	Nervous/Anxious	Yes	No			

Screening Questions (annually)

Do you feel safe in your home?	Yes	No
Do you feel safe in your relationship(s)?	Yes	No

Depression Over the last 2 weeks how often have you been bothered by the following problems?

Little interest or pleasure in doing things Not at all Several days More than ½ the days Nearly every day
Feeling down or depressed or hopeless? Not at all Several days More than ½ the days Nearly every day

Fall Risk

History of falling? Yes No	Use walking aids? Hold on to furniture? Yes No	Is your gait (walking style) steady? Yes No
Is your hearing impaired? Yes No	Is your vision impaired? Yes No	Do you have difficulty remembering or concentrating? Yes No