



1435 N. Randall Rd.
Suite 209
Elgin, IL 60123
847-695-1620
Fax 847-695-1954

25 North Winfield Rd.
Suite 201
Winfield, IL 60190
630-588-8920
Fax 630-588-8925

New Patient Questionnaire

DATE: _____

Office Use Only:

HT: _____ WT: _____ HR: _____

BP Right: _____ BP Left: _____

RR: _____ O2 Sat: _____

Why are you here to see the Doctor today? _____

What Doctor sent you to our office? _____

General Information

Name:		Date of Birth:
Primary language if not English:		Do you require an interpreter?
Home Address:		City/State:
Zip Code:	Cell #:	Home Phone #:
Employer:		Employer phone #:
What type of work do you do?		
Does your job involve heavy lifting or prolonged standing?		
Are you left-handed or right-handed?		
Would you prefer to be contacted at work or at home?		
May we leave messages with a family member at home or on your answering machine?		
Who lives with you at home?		

#1 Emergency Contact	Name:	Relationship:	Phone #:
#2 Emergency Contact	Name:	Relationship:	Phone #:

Do you have a living will or advance directive? _____ If yes, please specify: _____

Do you have a power of attorney for health care: _____

We encourage all patients to have Power of Attorney for health care. This tells us who you want to speak for you if you are unable to speak for yourself. We will supply you with the necessary forms.

Past Medical History

Please check the box if any of the following apply to you:

<input type="checkbox"/> Heart Attack	<input type="checkbox"/> Cancer	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Poor circulation	<input type="checkbox"/> On dialysis?
<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Stroke	<input type="checkbox"/> Varicose veins	<input type="checkbox"/> Blood clots in legs (DVT)	<input type="checkbox"/> Ever need
<input type="checkbox"/> High cholesterol	<input type="checkbox"/> Pulmonary embolus	<input type="checkbox"/> Vein stripping	<input type="checkbox"/> Pain in legs with walking	dialysis?
<input type="checkbox"/> Bad reaction to anesthesia?(specify)				

Please list all medications you are taking:

(Please include other medications such as aspirin, herbs, insulin, eye drops, and vitamins)

MEDICATION	DOSE	How Often Do You Take This?	What is it Taken For?

**PLEASE CONTINUE ON THE LAST PAGE IF NECESSARY.*

Do you or have you ever taken insulin for diabetes? _____

Are you allergic to any medication, food, environmental or other substance?

If yes, please specify allergy and reaction:

Have you ever had surgery? (Include eye surgery)

Surgery	Month/Year	Hospital, City, State

**PLEASE CONTINUE ON THE LAST PAGE IF NECESSARY.*

Have you had a serious illness requiring a hospital stay other than surgery?

Reason for Hospitalization	Month/Year	Hospital, City, State

**PLEASE CONTINUE ON THE LAST PAGE IF NECESSARY.*

NAME: _____

Social History:

Marital Status:	<input type="checkbox"/> Single	<input type="checkbox"/> Married	<input type="checkbox"/> Separated	<input type="checkbox"/> Divorced	<input type="checkbox"/> Widowed
Employment Status:	<input type="checkbox"/> Employed	<input type="checkbox"/> Retired	<input type="checkbox"/> Unemployed	<input type="checkbox"/> Other:	
Alcohol Use:	<input type="checkbox"/> Never	<input type="checkbox"/> Rarely	<input type="checkbox"/> Moderate (2-3 drinks weekly)	<input type="checkbox"/> Daily	
Tobacco Use:	<input type="checkbox"/> Never	<input type="checkbox"/> Previously, but quit smoking on:			(fill in date/year)
	<input type="checkbox"/> Currently smoke:	#Packs/Day	# Years		

Family History:(not yourself)

**Please check any of the following that apply to your blood relatives:*

HISTORY OF	YES	NO	Family Member(s)	HISTORY OF	YES	NO	Family Member(s)
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>		High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>		Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>		Bad Reaction to Anesthesia?	<input type="checkbox"/>	<input type="checkbox"/>	
Stroke	<input type="checkbox"/>	<input type="checkbox"/>		Other:			
Cancer (List type of Cancer)	<input type="checkbox"/>	<input type="checkbox"/>					

Review of Systems: Please indicate any personal history below:

<p>Constitutional Symptoms</p> <p>Good general health lately yes no</p> <p>Recent weight gain yes no</p> <p>Recent weight loss yes no</p> <p>Fever yes no</p> <p>Fatigue yes no</p> <p>Eyes</p> <p>Glaucoma yes no</p> <p>Cataracts yes no</p> <p>Other eye disease yes no</p> <p>Wear glasses/contact lenses yes no</p> <p>Blurred or double vision yes no</p> <p>Ears/Nose/Mouth/Throat</p> <p>Hearing loss or ringing yes no</p> <p>Earaches or drainage yes no</p> <p>Chronic sinus problem yes no</p> <p>Nose bleeds yes no</p> <p>Tooth or gum infection yes no</p> <p>Loose or damaged teeth yes no</p> <p>Sore throat or voice change yes no</p> <p>Swollen glands in neck yes no</p> <p>Cardiovascular</p> <p>Mitral valve prolapse yes no</p> <p>Chest pain or angina yes no</p> <p>Palpitation yes no</p> <p>Swelling feet/ankles yes no</p> <p>Rheumatic Fever yes no</p> <p>History of heart attack yes no</p> <p>Endocrine</p> <p>Thyroid problems yes no</p> <p>Diabetes yes no</p> <p>Hormonal problems yes no</p> <p>Heat intolerance yes no</p> <p>Cold intolerance yes no</p>	<p>Gastrointestinal</p> <p>Hepatitis yes no</p> <p>Peptic Ulcer Disease yes no</p> <p>Abdominal pain yes no</p> <p>Nausea or vomiting yes no</p> <p>Frequent diarrhea yes no</p> <p>Blood in Stool yes no</p> <p>Genitourinary</p> <p>Poor kidney function yes no</p> <p>Frequent urination yes no</p> <p>Burning or painful urination yes no</p> <p>Blood in urine yes no</p> <p>Incontinence or dribbling yes no</p> <p>Kidney stones yes no</p> <p>Women:</p> <p>Recurrent infections yes no</p> <p>Is there any chance you are pregnant? yes no</p> <p>Are you still menstruating?: _____</p> <p>Men:</p> <p>Trouble getting an erection yes no</p> <p>Prostate problems yes no</p> <p>Have you had a vasectomy yes no</p> <p>Musculoskeletal</p> <p>Arthritis yes no</p> <p>New pain in bones or joints yes no</p> <p>Muscle pain or cramps yes no</p> <p>Back pain yes no</p> <p>Difficulty in walking yes no</p> <p>Integumentary</p> <p>Varicose veins yes no</p> <p>Rash yes no</p> <p>Slow to heal yes no</p>	<p>Neurological</p> <p>Frequent headaches yes no</p> <p>Head injury yes no</p> <p>Seizures yes no</p> <p>Sudden blindness yes no</p> <p>Stroke yes no</p> <p>Fainting spells yes no</p> <p>Weakness in limb yes no</p> <p>Respiratory</p> <p>Tuberculosis yes no</p> <p>Asthma yes no</p> <p>Frequent bronchitis yes no</p> <p>Frequent pneumonia yes no</p> <p>Frequent coughs yes no</p> <p>Spitting up blood yes no</p> <p>Shortness of breath yes no</p> <p>Wheezing yes no</p> <p>Hematologic/Lymphatic</p> <p>Easy bleeding/bruising yes no</p> <p>Anemia yes no</p> <p>Phlebitis yes no</p> <p>Past transfusion yes no</p> <p>Enlarged glands yes no</p> <p>Sickle cell anemia yes no</p> <p>History of blood clots yes no</p> <p>Psychiatric</p> <p>Memory loss yes no</p> <p>Depression yes no</p> <p>Insomnia yes no</p> <p>Nervousness yes no</p> <p>Confusion yes no</p>
--	---	--

Please provide the names of any other Doctors you are currently seeing:

	NAME	OFFICE ADDRESS	OFFICE PHONE #
Family Doctor:			
Cardiologist (Heart doctor):			
Pulmonologist (Lung doctor):			
Podiatrist:			
Gastroenterologist:			
Ophthalmologist (Eye doctor):			
Endocrinologist:			
Other(specify):			
Other(specify):			
Other(specify):			
Other(specify):			
Other(specify):			

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the healthcare staff to perform the necessary service services I may need.

Signature of Patient, Parent or Legal Guardian

Date

