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NEW PATIENT QUESTIONNAIRE

Date: _____

What were you referred to see the doctor for? _____

What doctor sent you to our office? _____ Phone Number: _____

General Information

Name: _____ Male Female Date of Birth: _____

Preferred Language: _____ Do you require an interpreter? Yes No

Race (optional): Caucasian Black Hispanic Asian Native American Asian Pacific American Pacific Islander
Subcontinental Asian American American Indian or Alaskan Native Native American

Ethnicity (optional): Black Non-Hispanic White Non-Hispanic Hispanic Other: _____

Home Address: _____ City, State, Zip Code: _____

Home Phone Number: _____ Cell Phone Number: _____

Employer: _____ Employer Phone Number: _____

What type of work do you do? _____

If retired, what type of work did you do before retirement? _____

Does your job involve heavy lifting or prolonged standing? _____

Are You... Left-Handed Right-Handed

Would you prefer to be contacted at work or at home? _____ May we leave messages with a family member? Yes No

May we leave messages on your answering machine? Yes No Who lives with you at home? _____

May we have your e-mail address? _____

Emergency Contacts Name: _____ Relationship: _____

Phone: _____

Name: _____ Relationship: _____

Phone: _____

Do you have a living will or advance directive? Yes No If yes, please specify: _____

Do you have a power of attorney for health care? Yes No

Do you have religious objections to receiving blood even in a life-threatening circumstance? (Jehovah's Witness) Yes No

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 upon request.

Past Medical History

Please circle any of the following that apply to you:

Heart Attack Cancer Diabetes - On insulin, pills or diet? _____ Poor Circulation

On dialysis Ever needed dialysis High Blood Pressure Stroke TIA Varicose Veins

Blood Clots in legs (DVT) High Cholesterol Pulmonary Embolus (Blood clot in lung) Vein Stripping

Pain in Legs with Walking Bad Reaction To Anesthesia – Specify: _____

Other: _____

Do you have any prosthetics or implants? No Yes (Specify): _____

Preferred Pharmacy Name and Phone Number: _____

Please list all medications you are taking:

***Please include other medications such as aspirin, herbs, insulin, eye drops, & vitamins

Medication	Dose	How Often Do You Take This?	What Is It Taken For?

*Please continue on last page if necessary

Have you had a flu shot? Yes – When? _____ No

Have you had a pneumonia shot? Yes – When? _____ No

Please list any other recent immunizations: _____

Are you allergic to any medications, food, environmental, or other substance? ***Please specify ALLERGY & REACTION:

Have you ever had surgery?

Surgery	Month & Year	Hospital – Include City & State

*Please continue on last page if necessary

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

Reason for Hospitalization	Month & Year	Hospital – Include City & State

*Please continue on last page if necessary

Social History – Please Circle

Marital Status: Single Married Separated Divorced Widowed
Employment Status: Employed Retired Unemployed Other: _____
Alcohol Use: Never Occasionally Daily What do you drink? _____
 How many drinks per day? _____
Tobacco Use: Current Smoker Never Smoked Former Smoker
 How much do you smoke? _____ When did you quit? _____
 When did you start? _____ How much did you smoke? _____
 For how many years? _____

Family History (Not Yourself) Please circle any of the following that apply to your **blood relatives** (parents/siblings/children):
History Of: Family Member(s)

Heart Attack _____
 Stents in the heart _____
 Bypass surgery _____
 Other heart problems _____ At what age? _____
 Aneurysms _____
 Stroke..... _____
 Cancer – Type: _____
 Type: _____
 Easy Bleeding..... _____
 Arrhythmia..... _____
 Reactions to anesthesia..... _____
 Sudden death..... _____

Please Provide The Names of Any Other Doctors You Are Currently Seeing:

	Name (First and Last)	Office Address	Office Phone Number
Family Physician			
Cardiologist (Heart Doctor)			
Pulmonologist (Lung Doctor)			
Podiatrist (Foot Doctor)			
Gastroenterologist (Stomach Doctor)			
Ophthalmologist (Eye Doctor)			
Endocrinologist (Diabetes Doctor)			
Oncologist (Cancer Doctor)			
Other (Specify):			
Other (Specify):			

Have you ever had any of the following tests?

Stress test on the heart..... Yes No When/Where? _____
 MRI or CT scan..... Yes No When/Where? _____
 PET scan..... Yes No When/Where? _____
 Angiogram of blood vessels..... Yes No When/Where? _____
 Lung function test/pulmonary function test..... Yes No When/Where? _____
 Heart catheterization/angiogram..... Yes No When/Where? _____

Review Of Systems: *Please Indicate any personal history below:

Constitutional Symptoms			Gastrointestinal			Neurological		
Recent Weight Gain	Yes	No	Hepatitis	Yes	No	History of a coma	Yes	No
Recent Weight Loss	Yes	No	Peptic Ulcer Disease	Yes	No	Head Injury	Yes	No
Fever	Yes	No	Hiatal Hernia	Yes	No	Seizures	Yes	No
Fatigue	Yes	No	Reflux (GERD)	Yes	No	Stroke	Yes	No
Eyes						Fainting Spells	Yes	No
Eye Surgery	Yes	No	Genitourinary			TIA	Yes	No
Sudden Loss of Vision	Yes	No	Poor Kidney Function	Yes	No	Carotid Blockage	Yes	No
Glaucoma	Yes	No	On Dialysis?	Yes	No	New headaches or balance changes	Yes	No
Cataracts	Yes	No	Ever needed Dialysis? When? _____	Yes	No			
Other Eye Disease	Yes	No	Kidney Stones	Yes	No	Respiratory		
Wear Glasses/Contact Lenses	Yes	No	Recurrent urinary tract infections	Yes	No	Tuberculosis	Yes	No
Blurred or Double Vision	Yes	No				Asthma	Yes	No
Ears/Nose/Mouth/Throat			Women:			Frequent Bronchitis	Yes	No
Hearing Aids	Yes	No	Any Chance You Are Pregnant?	Yes	No	Frequent Pneumonia	Yes	No
Chronic Sinus Problem	Yes	No	Are you still menstruating?	Yes	No	Frequent Coughs	Yes	No
Nose Bleeds	Yes	No				Spitting up Blood	Yes	No
Active mouth or gum infection	Yes	No	Men:			Shortness of Breath	Yes	No
Loose or Damaged Teeth	Yes	No	Trouble Getting an Erection	Yes	No	Wheezing	Yes	No
Sore Throat or Voice Change	Yes	No	Prostate Problems	Yes	No	COPD	Yes	No
Swollen Glands in Neck	Yes	No	Have you had a vasectomy	Yes	No	Recent cold or pneumonia	Yes	No
Cardiovascular			Penile prosthesis	Yes	No			
Mitral Valve Prolapse	Yes	No				Hematologic/Lymphatic		
Palpitations	Yes	No	Musculoskeletal			Easy Bleeding/Bruising	Yes	No
Pacemaker	Yes	No	Arthritis	Yes	No	Anemia	Yes	No
Chest Pain or Angina	Yes	No	New Pain in Bones or Joints	Yes	No	Phlebitis	Yes	No
Rheumatic Fever	Yes	No	Muscle Pain or Cramps	Yes	No	Past Transfusion	Yes	No
History of Heart Attack	Yes	No	Back Pain	Yes	No	Enlarged Glands or lymph nodes	Yes	No
Aneurysm	Yes	No	Difficulty in Walking	Yes	No	Sickle Cell Anemia or Trait	Yes	No
Heart or valve infection (Endocarditis)	Yes	No	Do you use a cane, walker, or wheelchair?	Yes	No	History of Blood Clots	Yes	No
Endocrine			Spine surgery	Yes	No			
Overactive thyroid	Yes	No				Psychiatric		
Underactive thyroid	Yes	No	Integumentary			Alzheimer's	Yes	No
Diabetes (Type: _____)	Yes	No	Varicose Veins	Yes	No	Depression	Yes	No
Do you use insulin?	Yes	No	Rash	Yes	No	Severe Anxiety	Yes	No
Vascular			Slow to Heal	Yes	No			
Cramping of the arms or legs with activity or at rest	Yes	No	Skin Cancer	Yes	No			
Aortic aneurysm	Yes	No						
Blood vessel surgery	Yes	No						
Angiogram or stent to a blood vessel not in the heart	Yes	No						
Intracranial aneurysm	Yes	No						

- 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 authorize the healthcare staff to perform the necessary services I may need.

Signature of Patient, Parent, or Legal Guardian

Date

