

UCSF Medical Center

**AMBULATORY SERVICES**

NEW PATIENT INFORMATION FORM

UNIT NUMBER PT. NAME BIRTHDATE

LOCATION DATE

775-072 (Rev. 05/01) MEDICAL RECORD COPY

Today’s Date / /

What is the reason for your visit today?

Where have you been receiving your medical care?

Name of Physician Address

|  |  |  |
| --- | --- | --- |
| Hepatitis | Yes | No |
| High Blood Pressure | Yes | No |
| Immune Disorders | Yes | No |
| Intestinal Problems | Yes | No |
| Kidney Disease | Yes | No |
| Liver Disease | Yes | No |
| Lung Disease | Yes | No |
| Skin Disease | Yes | No |
| Stroke | Yes | No |
| Stomach Ulcers | Yes | No |
| Thyroid Disease | Yes | No |
| Other (describe) | Yes | No |

Street Address City State Zip Code

**PAST MEDICAL HISTORY:** Please circle Yes or No for any illnesses that you have had:

|  |  |  |
| --- | --- | --- |
| Anemia | Yes | No |
| Arthritis | Yes | No |
| Asthma / Bronchitis / Emphysema | Yes | No |
| Bleeding / Bruising | Yes | No |
| Blood Disorder | Yes | No |
| Cancer (type): | Yes | No |
| Depression / Emotional Problems | Yes | No |
| Diabetes | Yes | No |
| Drug / Alcohol Dependency | Yes | No |
| Epilepsy / Seizures | Yes | No |
| Hay Fever / Sinus Problems | Yes | No |
| Heart Problems | Yes | No |

Have you ever been hospitalized? Yes No If yes, please list the date(s) and reason(s):

Have you had any surgeries? Yes No If yes, please list the date(s) and type(s) of surgery:

Please list any medications you take, including prescription drugs, over-the-counter drugs, eye drops, vitamins, minerals, and herbs:

Name of Medication Dose or Strength How often do you take it?

Have you ever had an allergic reaction to a medication? Yes No If yes, which medication(s)?

Medication Reaction

Have you ever had an allergic reaction to any of the following?

Latex Yes No Iodine Yes No Other allergies: Insect stings Yes No Food Yes No (If yes,describe)

**FAMILY HISTORY:** Have any members of your family, (including grandparents, parents, siblings, and children), had any of the following?

|  |  |  |  |
| --- | --- | --- | --- |
| Problem | Circle Yes or No | | Family Relationship |
| Alcoholism / Substance Abuse | Yes | No |  |
| ALS (Lou Gehrig’s Disease) | Yes | No |  |
| Alzheimer’s / Dementia | Yes | No |  |
| Anemia / Bleeding Problems | Yes | No |  |
| Cancer (Breast, Ovarian, Colon, Other) | Yes | No |  |
| Depression / Other Mental Illness | Yes | No |  |
| Diabetes | Yes | No |  |
| Heart Disease / Angina | Yes | No |  |
| Hepatitis / Liver Disease | Yes | No |  |
| High Blood Pressure | Yes | No |  |
| High Cholesterol | Yes | No |  |
| Kidney Disease | Yes | No |  |
| Osteoporosis | Yes | No |  |
| Seizure Disorders | Yes | No |  |
| Stroke | Yes | No |  |
| Thyroid Disease | Yes | No |  |
| Tuberculosis | Yes | No |  |
| Other (please describe): | Yes | No |  |

Family Tree (please leave this area blank for your provider):

**SOCIAL HISTORY:** Please tell us about your lifestyle and personal habits. It is OK if you choose not to answer

any of these questions.

What is your occupation?

Are your retired? Yes No

Do you live alone? Yes No If no, who do you live with? Do you follow any special diet? Yes No If yes, describe Do you have concerns about your nutrition? Yes No If yes, describe Do you exercise regularly? Yes No If yes, describe Do you use chewing tobacco or snuff? Yes No Do you smoke cigars or cigarettes? Yes No

|  |  |
| --- | --- |
| If the answer is **Yes**, answer the questions below: | If the answer is **No**, answer the questions below: |
| For how many years have you smoked? | Have you smoked in the past? Yes No |
| How many packs per day do you smoke? | How many packs per day did you smoke? |
| Are you interested in quitting? | When did you quit? |

|  |  |  |
| --- | --- | --- |
| Do you drink alcohol? Yes No If yes, please answer the questions in the box: |  | |
| During the last week, on how many days have you had a drink? |
| On days when you had a drink, how many drinks (beer, wine, or liquor) did you have? |
| Have you ever felt that you ought to cut down on your drinking? | Yes | No |
| Have people criticized your drinking? | Yes | No |
| Have you ever felt bad or guilty about your drinking? | Yes | No |
| Have you ever had to have a drink first thing in the morning  to steady your nerves or get rid of a hangover? | Yes | No |
| Have you ever had blackouts or memory loss? | Yes | No |

Do you use or take any drugs such as marijuana, cocaine, stimulants, or sedatives? Yes No

If yes, describe

Have you ever injected any drugs? Yes No

Have you had sex with men? Yes No Have you had sex with women? Yes No

Do you and your sexual partner(s) practice safe sex? Yes No Not sure

Risk factors for infection with HIV, the AIDS virus, include anal intercourse or vaginal intercourse with multiple partners, intravenous drug use, hemophilia, past history of a blood transfusion between 1979-1985, and sexual con- tact with an HIV-positive individual or other person with these risk factors. If you have any of these risk factors, or are interested in being tested for HIV infection, please discuss this with your health care provider.

In the last 12 months, have you been hurt or felt threatened by someone close to you? Yes No During the past month, have you felt “down” or depressed? Yes No Do you have trouble finding pleasure in things you used to enjoy? Yes No Have you ever been so sad that you thought about hurting yourself? Yes No

**PREVENTIVE CARE:**

|  |  |  |  |
| --- | --- | --- | --- |
| Have you received a vaccine to prevent any of the  following diseases? If yes, please list date. | | | |
| Tetanus (DT) | No | Yes | Date: |
| Influenza (flu) | No | Yes | Date: |
| Pneumonia | No | Yes | Date: |
| Hepatitis B | No | Yes | Date: |
| Rubella / MMR | No | Yes | Date: |

colonoscopy

|  |  |  |  |
| --- | --- | --- | --- |
| Have you ever had any of these screening tests done?  If yes, please give date of last test. | | | |
| Cholesterol | No | Yes | Date: |
| Tuberculin skin test | No | Yes | Date: |
| Stool test for blood | No | Yes | Date: |
| Sigmoidoscopy or | No | Yes | Date: |
| Mammogram | No | Yes | Date: |

Do you have any problem paying for medical care? Yes No

**PAIN & FUNCTIONAL STATUS:** As health care providers, we are concerned about your comfort. Do you suffer from pain? Yes No If yes, answer the questions in the box below:

Where is your pain? What does your pain feel like? Circle a number from 0-10 that best describes how much pain you are having now:

1 2 3 4 5 6 7 8 9 10

No Pain Worst Pain Possible

What makes the pain better? What makes the pain worse? Does the pain limit your activity or interfere with your sleep? If yes, please describe:

Please list any medication(s) or other type(s) of treatment you use for pain relief:

An Advance Health Care Directive is a document that provides instructions regarding your medical care in the event of serious medical problems. It also allows you to define who may make health care decisions for you if you are unable to make decisions for yourself. It has previously been called a “Living Will” or “Durable Power of Attorney for Health Care.”

Do you have an Advance Health Care Directive? Yes No

If no, would you like information about Advance Directives? Yes No

If you are older than age 65 or have any chronic medical condition(s) please answer the following: Do you have any difficulty bathing or dressing yourself? Yes No

Do you ever lose control over your urination or bowel movements? Yes No

Have you had 3 or more falls in the past year? Yes No

Have you experienced any change in your ability to do your usual activities? Yes No

Are you receiving any special help at home? Yes No

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Have you experienced any of the following **in the past 3-6 months?** | Yes | No | Patient Comments | Provider Comments |
| change in general health recent weight changes  recurrent fevers, chills, or sweats heat or cold intolerance  extreme fatigue change in appetite excess thirst or urination difficulty sleeping |  |  |  |  |
| nervousness / anxiety  difficulty sleeping depression  delusions / hallucinations |  |  |  |  |
| easy bruising  frequent or prolonged bleeding enlarged Iymph nodes  decreased resistance to infection |  |  |  |  |
| unusual rash / skin problems delayed healing  change in hair or nails |  |  |  |  |
| headaches  numbness / tingling sensation weakness / paralysis convulsions / seizures  confusion / change in memory or concentration black outs / dizziness |  |  |  |  |
| change in hearing / ringing in ears recent nose bleeds  chronic sinus problems / runny nose allergy symptoms  voice changes recurrent sore throat difficulty swallowing |  |  |  |  |
| wear glasses or contact lenses  change in vision  pain or irritation in eye(s)  redness or discharge from eye(s) |  |  |  |  |
| breathing problems / shortness of breath  chronic cough coughing-up blood |  |  |  |  |
| chest pain or angina  irregular heart rhythm / palpitations swelling of feet, ankles, hands |  |  |  |  |
| breast pain  breast lump or swelling |  |  |  |  |
| severe heartburn nausea or vomiting vomiting blood abdominal pain constipation frequent diarrhea  black or bloody stools |  |  |  |  |
| joint / muscle stiffness, pain, weakness neck pain / back pain  difficulty walking |  |  |  |  |

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| --- | --- | --- | --- | --- |
| Please answer the following questions: | Yes | No | Patient Comments | Provider Comments |
| Have you ever had a mammogram?  (If yes, please give date and results of last mammogram and where mammogram was done) |  |  | Date: Results: Where done: |  |
| Have you ever had an abnormal mammogram?  (If yes, please give date, results, and treatment) |  |  | Date:  Results: Treatment: |  |
| Do you routinely practice self-breast exams? |  |  |  |  |
| Have you ever had:  sexually transmitted disease genital or anal warts |  |  |  |  |
| When was your last PAP smear? |  | | Date:  Results: |  |
| Have you ever had an abnormal PAP smear? (If yes, please give date, results, and treatment) |  |  | Date: Results: Treatment: |  |
| Do you have problems with any of the following:  urinary frequency / urgency frequent urination at night  lack of bladder control / incontinence painful urination  blood in urine  recurrent urinary tract infections vaginal discharge  vaginal pain / itching / irritation vaginal dryness  hot flashes  change in sex drive  bleeding between periods / after menopause |  |  |  |  |
| How old were you when you had your first  menstrual period? |  | | Age: |  |
| Do you still have menstrual periods? |  |  |  |  |
| If you are still having periods, on what day did  your last period start? |  | | Date: |  |
| Are your periods regular? |  |  |  |  |
| How many days are there between periods? |  | | Days: |  |
| How long does your period last? | Days: |  |
| How would you describe your periods? (circle) |  |  | Heavy Moderate Light |  |
| Are your periods painful? |  |  |  |  |
| Have you ever been on hormone replacement  therapy? ( If yes, give dates / type) |  |  | Dates:  Types: |  |
| Have you ever been pregnant?  (If yes, please fill-in total number of pregnancies, deliveries, miscarriages, and abortions) |  |  | # of pregnancies:  # of deliveries:  # of miscarriages:  # of abortions: |  |
| Did you have complications with a pregnancy? (If yes, please describe) |  |  | Complications: |  |
| Do you currently use any form of birth control?  (If yes, please state type used) |  |  | Birth control used: |  |

Instructions to Provider: Your signature below indicates that you have reviewed the information contained in this questionnaire and you have reviewed the pertinent or key findings with the patient and/or family. Key findings must be summarized in your progress note; however, the questionnaire may be referenced for additional details.

Signature Date / /

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|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Please answer the following questions: | Yes | No | Patient Comments | Provider Comments |
| Have you had problems with:  testicular pain  impotence / change in sexual function prostate problems  urinary problems:  difficulty starting stream urinary frequency  frequent urination at night  lack of bladder control / dribbling painful urination  blood in urine  recurrent urinary tract infections other (describe) |  |  |  |  |
| Have you ever had:  sexually transmitted disease genital warts  anal warts |  |  |  |  |
| Have you ever been screened for prostate cancer?  If yes, was it a digital rectal exam? Have you had a PSA blood test? |  |  |  |  |
| Do you routinely practice testicular self-exams? |  |  |  |  |

Instructions to Provider: Your signature below indicates that you have reviewed the information contained in this questionnaire and you have reviewed the pertinent or key findings with the patient and/or family. Key findings must be summarized in your progress note; however, the questionnaire may be referenced for additional details.

Signature Date / /