University of California
San Francisco

UCSF

UCSF Medical Center
AMBULATORY SERVICES

UNIT NUMBER

PT. NAME

BIRTHDATE

LOCATION DATE

NEW PATIENT INFORMATION FORM

Today's Date _____ / _____ / _____

What is the reason for your visit today? _____

_____

_____

Where have you been receiving your medical care?

Name of Physician _____

Address _____
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

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

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 contact 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:

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 colonoscopy	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

<u>If you are older than age 65 or have any chronic medical condition(s) please answer the following:</u>

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

REVIEW OF SYSTEMS:

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 lymph 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				

FOR WOMEN ONLY:

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 _____ / _____ / _____

FOR MEN ONLY:

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 _____ / _____ / ___