Yale HEALTH

Adult New Patient Questionnaire

Date completed: _____/_____/_____

PERSONAL INFORMATION

Name: _____ Date of birth: _____/_____/_____

What is your primary language? _____

Do you have special needs in any of the following areas?

❑ Reading ❑ Vision ❑ Hearing ❑ Mobility (e.g., wheelchair, walker, etc.) ❑ Communication (e.g., need for a translator)

HOME

❑ Single ❑ Long-term partner ❑ Married ❑ Civil Union ❑ Divorced ❑ Separated ❑ Widowed

List your children with ages: _____

_____

List current members of your household: _____

EMPLOYMENT

❑ Full-time ❑ Part-time ❑ At home/homemaker ❑ Looking ❑ Disabled ❑ Retired ❑ Student, school:_____

Current occupation: _____ Former occupation (if retired): _____

Employer: ❑ Yale Department: _____ ❑ Other: _____

ALLERGIES List medication allergies and the type of reaction you had. ❑ I have no drug allergies

_____ _____

_____ _____

MEDICATIONS List with doses. Include contraceptives, vitamins, supplements, etc. Attach list if needed. ❑ None

_____ _____

_____ _____

_____ _____

_____ _____

Name: _____

YOUR MEDICAL CONDITIONS (check all that apply)

- ❑ Allergies
- ❑ Anemia
- ❑ Anxiety
- ❑ Arthritis
- ❑ Asthma
- ❑ Blood transfusion
- ❑ Cancer
- ❑ Clotting disorder
- ❑ Congestive heart failure
- ❑ Depression
- ❑ Diabetes mellitus
- ❑ Emphysema/COPD
- ❑ Gastroesophageal reflux disease (GERD)
- ❑ Glaucoma
- ❑ Heart murmur
- ❑ HIV/AIDS
- ❑ High cholesterol
- ❑ Hypertension/high blood pressure
- ❑ Kidney disease
- ❑ Myocardial infarction
- ❑ Nerve/muscle disease
- ❑ Osteoporosis
- ❑ Seizures
- ❑ Sickle cell anemia
- ❑ Substance abuse
- ❑ Thyroid disease
- ❑ Tuberculosis

Details/Other: _____

SURGICAL HISTORY (check all that apply)

- ❑ Appendectomy
- ❑ Brain surgery
- ❑ Breast surgery
- ❑ CABG
- ❑ Cholecystectomy
- ❑ Colon surgery
- ❑ Tonsillectomy
- ❑ Appendectomy
- ❑ Thyroid surgery
- ❑ Lung surgery
- ❑ C-section
- ❑ Eye surgery
- ❑ Fracture surgery
- ❑ Hernia repair
- ❑ Hysterectomy
- ❑ Joint surgery
- ❑ Bunionectomy
- ❑ Varicose vein surgery
- ❑ Prostate surgery
- ❑ Weight reduction surgery
- ❑ Small intestine surgery
- ❑ Spine surgery
- ❑ Tubal ligation
- ❑ Valve replacement
- ❑ Vasectomy
- ❑ Vascular surgery
- ❑ Cardiac stent
- ❑ Bladder surgery

Have you ever had a blood transfusion? ❑ No ❑ Yes, approximate dates: _____

FAMILY HISTORY (check all that apply)

	Alcohol abuse	Breast cancer	Ovarian cancer	Prostate cancer	Other cancer(s)	Diabetes	Heart disease	High cholesterol	Hypertension	Mental illness
Mother										
Father										
Sister										
Brother										
Daughter										
Son										
Other relative										

Other family history: _____

HABITS AND ACTIVITIES

Do you use tobacco? ❑ No ❑ Yes, what form? _____ How much?_____ For how long?_____
❑ In the past How many years ago did you quit? _____
Have you tried to quit? ❑ No ❑ Yes Would you like to quit? ❑ No ❑ Yes

Do you drink alcohol? ❑ No ❑ In the past ❑ Yes, how many drinks per week? _____

Do you, or have you ever used recreational drugs? ❑ No ❑ Yes, describe: _____

Do you get regular exercise? ❑ No ❑ Yes, what kind of exercise? _____
How often? ❑ Daily ❑ More than 30 minutes 3 times per week ❑ One or two times per week

List any hobbies or leisure activities:

_____

Name: _____

IMMUNIZATIONS

Vaccination	Approximate Date	Never
Pneumonia (pneumovax)	_____	❑
Tetanus booster (Tdap)	_____	❑
TB skin test (PPD)	_____	❑
Hepatitis B vaccine	_____	❑
Hepatitis A vaccine	_____	❑
Varicella (chicken pox)	_____	❑
Shingles (Zostavax)	_____	❑

PREVENTIVE CARE

Test or Procedure	Date and Result	Never
Colonoscopy	_____	❑
Bone density test (DXA)	_____	❑
Cholesterol test	_____	❑
PSA (prostate cancer test)	_____	❑
Pap smear	_____	❑
Mammogram	_____	❑
HIV test	_____	❑

List any abnormal screening test results (e.g. polyps, breast biopsies, etc.): _____

_____

SEXUAL HISTORY

My sexual partners have been: ❑ Male ❑ Female ❑ Both ❑ Never Sexually Active

Have you had more than one sexual partner in the past year? ❑ No ❑ Yes

Have you ever had a sexually transmitted disease? ❑ No ❑ Yes, what and when? _____

GYNECOLOGICAL AND OBSTETRIC HISTORY

How many times have you been pregnant? _____ Live births? _____ Miscarriages? _____ Abortions? _____

Do you use contraception? ❑ No ❑ Yes, what kind? _____

What was your age at first menses? _____ Menstrual periods: ❑ Regular ❑ Irregular ❑ Menopausal

Age at menopause? _____ Do you have hot flashes or other symptoms (specify)? _____

Any gynecological conditions or problems? _____ Name: _____

OTHER HEALTH ISSUES

Do you feel unsafe, or have you been harmed in a physical, emotional or sexual manner, in any relationship or recent encounter? ❑ No ❑ Yes, describe: _____

Name: _____

In the past year, have you had two weeks or more during which you felt sad, blue or depressed or when you have lost all interest or pleasure in things that you usually care about or enjoyed? ❑ No ❑ Yes, describe: _____

_____

In the past year, have you had any major life changes or stresses that you feel have impacted your overall health?
❑ No ❑ Yes, describe: _____

_____

ADDITIONAL COMMENTS OR CONCERNS

_____

_____

_____

_____

_____

If you have not already done so, please ask your current medical providers to forward a copy of your medical records to Yale Health, by completing a Release Your Medical Records to Yale Health form available online at yalehealth.yale.edu/forms.

For more information about transferring your medical records to Yale Health, contact Yale Health's Health Information Services Department at 203-432-7741.

Submission Instructions

We would like to have this form completed and returned prior to your first appointment in Internal Medicine.

Please fax the form to Internal Medicine at 203-432-1386.

If you cannot fax the form and your appointment is **less than two weeks away**, please bring it with you to your first appointment in Internal Medicine.

If your appointment is **more than two weeks away,** you may mail the form to:

Yale Health Center
55 Lock Street
PO Box 208237
New Haven, CT 06520-8237
Attn: Health Information Management