Complete Physical/New Patient Questionnaire

BAYVIEW PHYSICIANS GROUP

Today's Date: _____

Name: _____ **DOB:** _____

Previous Physician's Name (have you requested records Y or N date of request ___/___/___) _____

Current and Previous Medical Specialist.

_____

_____

_____

_____

Please check below if you consent to the following:

☐ I agree that Bayview Physician Services, PC. may request and use my prescription medication history from other healthcare providers or third-party pharmacy benefit payors for treatment purposes.

List the date and location of you most recent hospitalization and reasons for hospitalization.

_____

_____

_____

_____

Today's Particular Health Concerns:

1 _____

2 _____

3 _____

Overall Health:

How often do you exercise and what do you do?

How many servings of fresh fruits and vegetables do you eat a day? 1 2 3 4 5

The last time you had an eye exam?_____ dental exam?_____

Do you wear your seatbelt? Y N Do you wear sunscreen? Y N

Do you have smoke detectors? Y N

Do you feel safe in your home? Y N In your current relationships? Y N

Allergies: Environmental/Food/Medications

Medications and Dosages (include non-prescription medications, vitamins and birth control)

1	**5**	**9**
2	**6**	**10**
3	**7**	**11**
4	**8**	**12**

Past Medical History (Problems for which you take *medication* or were *hospitalized*)**:**

Heart-	**Lungs-**	**Gastrointestinal-**
Neurologic-	**Musculoskeletal-**	**Kidney-**
Cancer-	**Other-**	**Other-**

Past Surgeries and Dates (including tonsils, appendix, vasectomies, tubal ligations, etc…)

Patient Name: _____ **DOB:** _____

Family Medical History (and age at which someone in your family was diagnosed or died):

History of:	***Family Member:***	***History of:***	***Family Member:***	***History of:***	***Family Member:***
Heart Disease:		High Cholesterol:		Glaucoma:	
High BP:		Lung Disease:		Kidney Disese:	
Stroke/TIA:		Asthma:		Cancer, Breast:	
Diabetes:		Anemia/Blood:		Cancer, Colon etc.:	
Thyroid:		Alzheimers Disease:		Depression:	

Social History:

Do you smoke? ☐ Never Smoked ☐ Former Smoker/Quit (How long? _____) ☐ Smoke Everyday
☐ Smoke Sometimes (Avg pack per day_____)

How much do you smoke per day? _____ How many alcoholic drinks per day? _____

Do you use any other drugs? _____ Are you single, married, divorced, or other? _____

Do you use chewing tobacco? ☐ Never ☐ Sometimes ☐ Daily ☐ Quit (When? _____)

Are you sexually active? Y N Do you want testing for sexually transmitted diseases? Y N

What is your employment? _____

Immunizations: (If filled out for a child, include *immunization record*)

When was your last tetanus shot? _____ Flu shot? _____

Pneumovax (pneumonia shot)? _____ Zostavax (shingles shot)? _____

Health Maintenance:

Date of your last colonoscopy? _____ Date you need repeat colonoscopy: _____

How often you have menses (women only)? _____ Date of last menses: _____

Date of last pap smear (women only)? _____ Dates of abnormal Pap smears: _____

Date of last mammogram (women only)? _____ Date you need repeat mammogram: _____

No. of Pregnancies (women only)? _____ No. of Births (women only)? _____ No. of Miscarriages (women only)? _____

Review of Systems: *(Please circle complaints that are present)*

Category:	**Symptoms:**
General Symptoms:	fever, chills, night sweats, fatigue weight loss
Eyes:	blurry, vision, eye pain
Ears, Nose, Mouth, Throat:	runny nose/nasal congestion, sore throat, headaches, difficulty hearing, difficulty swallowing
CV:	chest pain, palpitations, swelling in limbs, shortness of breath with activity, pain in limbs when walking
Resp:	shortness of breath, cough, wheezing, snoring
GI:	abdominal pain, nausea, vomiting, diarrhea, constipation, heartburn, blood in stool
MSK:	muscle aches, cramping, joint swelling, joint pain, recent trauma
Integumentary:	rash, itching, changes in moles
Neuro:	numbness, weakness, passing out, difficulty walking, speaking, concentrating or remembering
Psych:	anxiety, panic attacks, depression, mania, thoughts of self harm
Endo:	increased thirst or hunger, unexplained weight change, heat or cold intolerance
Heme/Onc:	abnormal bleeding, easy bruising, frequent infections
All/Imm:	environmental allergies, drug allergies, immune deficiency