SUNCOAST
INTERNAL MEDICINE CONSULTANTS
A MULTI-SPECIALTY CLINIC

New IM Patient Questionnaire

Date Completed_____

Personal Information

Name_____Date of Birth:_____

Do you have special needs in the following areas?

□Reading □Vision □Mobility (wheelchair, walker, etc) □Hearing □Communication

HOME

□Single □Married □Long-Term Partner □Divorced □Separated □Widowed

Children's Ages_____

Current members of your household_____

EMPLOYMENT

□Full-Time □Part-Time □At Home/Homemaker □Looking □Disabled □Retired □Student

Current occupation_____Former Occupation_____

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 ❑ N Name: _____

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 the things that you usually care about or enjoy? □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

_____

_____

_____

_____