UCLA Health System

MRN:
Patient Name:

(Patient Label)

UCLA National Center of Excellence In Women's Health

NEW PATIENT QUESTIONNAIRE

Name: _____ Date: _____

Occupation: _____ UCLA ID# _____

Emergency Contact: _____

Name: _____

Phone Number: _____

Relationship to you: ☐ Spouse ☐ Significant Other ☐ Friend ☐ Child ☐ Other (describe) _____

Who referred you to this office? _____

Were you adopted ☐ No ☐ Yes If yes, please complete the table below for for biological family, if known, otherwise skip to question 1.

Please consider the following medical problems, as well as any others you know of, when completing our family history below:

High Blood Pressure	Breast Cancer	Alcohol or Drug Problem
Diabetes	Colon Cancer	Depression
Heart Attack, Bypass Surgery,	Skin Cancer	Other Mental Illness
Angina (heart pain)	Ovarian Cancer	Thyroid Problem
Liver Disease	Other Cancer	Kidney Problem
Asthma	Osteoporosis	Intestinal Problem
Allergies or Hay Fever	High Cholesterol	Broken Bones as an Adult
Tuberculosis		

FAMILY HISTORY:

Relative	Age (if living)	Medical Problems	If deceased, cause of death and age at death
Father			
Mother			
Brothers			
Sisters			
Children			
Other			

UCLA New Patient Questionnaire (Cont.)

1. What problems, questions or concerns do you want to discuss with the physician?

2. Do you have a durable power of attorney for healthcare, and/or a living will? …….. ☐ No ☐ Yes

3. Where were you born? _____

4. In the past year, have you regularly taken any prescription medicines?.... ☐ No ☐ Yes (please list)

Name of Medicine	Dose	What Used For

5. Do you take any "over the counter" medicines, herbal or homeopathic preparations, or vitamins, minerals or supplements?..... ☐ No ☐ Yes (please list)

Name of Medicine	Dose	What Used For

6. Put all drugs or medications and/or products to which you are allergic or had a bad reaction:

_____

_____

_____

_____

PAST MEDICAL AND SURGICAL HISTORY

7. Have you had operations during your lifetime? …… ☐ No ☐ Yes (please list)

1. Type: _____ Year: _____
2. Type: _____ Year: _____
3. Type: _____ Year: _____
4. Type: _____ Year: _____
5. Type: _____ Year: _____

UCLA New Patient Questionnaire (Cont.)

8. Have you stayed in the hospital overnight for any reason other than an operation or childbirth? Please explain here: ☐ No ☐ Yes

9. Have you had broken bones or had an accident which required medical treatment? Please explain here: ☐ No ☐ Yes

10. Has a doctor said you have (a) :

Osteoporosis	☐ No ☐ Yes
Emphysema, chronic bronchitis	☐ No ☐ Yes
Allergies or hay fever	☐ No ☐ Yes
Asthma	☐ No ☐ Yes
Heart problem	☐ No ☐ Yes
High blood pressure	☐ No ☐ Yes
Lung problem other than asthma, emphysema, chronic bronchitis	☐ No ☐ Yes
Positive skin test for Tuberculosis (TB)	☐ No ☐ Yes
GERD, reflux, hiatal hernia	☐ No ☐ Yes
Stomach or duodenal ulcer	☐ No ☐ Yes
Hepatitis or liver problems	☐ No ☐ Yes
Irritable bowel syndrome (IBS)	☐ No ☐ Yes
Kidney problems	☐ No ☐ Yes
Cancer	☐ No ☐ Yes
Gallstones, gallbladder disease	☐ No ☐ Yes
Hemorrhoids	☐ No ☐ Yes
Pancreas problem	☐ No ☐ Yes
Bladder infection	☐ No ☐ Yes
Arthritis	☐ No ☐ Yes
Gout	☐ No ☐ Yes
Fibromyalgia	☐ No ☐ Yes
Depression	☐ No ☐ Yes
Diabetes	☐ No ☐ Yes
Thyroid problems	☐ No ☐ Yes

11. Any other medical problems? Please explain here: ☐ No ☐ Yes

12. Did you ever have a blood transfusion? ☐ No ☐ Yes If yes, year of transfusion _____
Please explain here: _____

SOCIAL HISTORY

13. Have you ever smoked cigarettes?
☐ No
☐ Yes, but quit in _____ (year quit), had smoked _____ cigarettes a day
☐ Yes, currently smoke _____ cigarettes a day, started at age _____

14. Do you use tobacco other than cigarettes? …….. ☐ No ☐ Yes

15. In an average week, how many glasses of wine, beer or liquor do you drink? …… ☐ None ☐ 1 – 7 ☐ more than 7

16. How many drinks does it take before you feel the first effects of alcohol? ……. ☐ 1 or 2 ☐ 3 or more

17. Have close friends or relative warned or complained about your drinking in the … past year? ☐ No ☐ Yes

18. Do you sometimes take a drink in the morning when you first get up? …… ☐ No ☐ Yes

19. Has a friend or family member every told you about things you said or did while .. you were drinking that you could not remember? ☐ No ☐ Yes

20. Do you sometimes feel you need to cut down on your drinking? …….. ☐ No ☐ Yes

21. Do you exercise? ☐ No (explain reason) _____

☐ Yes (how much and how often) _____

22. In the past year, have you been hit, kicked, punched, or otherwise …….. ☐ No ☐ Yes hurt by someone?

23. Who live with you?
☐ I live alone
☐ I live with friends
☐ I live with family or spouse/significant other
☐ I live with roommates

24. Have you had sex within the past year? …… ☐ No ☐ Yes
If yes, with ……. ☐ Men ☐ Women ☐ Both
If yes, with how many partners …….. ☐ 1 ☐ 2 ☐ More

UCLA New Patient Questionnaire (Cont.)

REVIEW OF SYSTEM

25. How old were you when your menstrual period began …… _____

26. Are you still having menstrual periods? …… ☐ No ☐ Yes
    If no, how old were you when you stopped? ……. _____

27. If you are still having periods (if not, SKIP to 29)
    - Do you have a period every month? …… ☐ No ☐ Yes
    - Are you regular? …… ☐ No ☐ Yes
    - How many days do you bleed? …… _____
    - Do you spot between periods? …… ☐ No ☐ Yes
    - Are your periods heavy? …… ☐ No ☐ Yes
    - Do you have painful periods that bother you or cause you to take ……... ☐ No ☐ Yes medication?

28. Are you pregnant? …… ☐ No ☐ Yes

29. If you are no longer having periods, have you had any bleeding from ……. ☐ No ☐ Yes the vagina in the past year?

30. Are you currently using any method of contraception? …… ☐ No ☐ Yes
    (please describe) _____

31. How many times have you been pregnant? _____

32. How many children have you had? _____

33. Do you ever lose urine unintentionally? …….. ☐ No ☐ Yes

34. Have you had burning while urinating in the past month? …… ☐ No ☐ Yes

35. What is the **least** you have weighed since age 20? _____lbs Age _____

36. What is the **most** you have weighed since age 20? _____lbs. Age _____

37. Have you gained or lost more than 10 lbs. In the past year? …… ☐ No ☐ Yes (how much) __

38. Are you shorter in height now than you used to be? …… ☐ No ☐ Yes

39. Have you had a fever in the last month? …….. ☐ No ☐ Yes

40. Do you wear glasses or contacts? …….. ☐ No ☐ Yes

41. When was your last eye exam? _____ (month) _____ (year)

42. Do you have problems with your vision, that your current glasses …….. ☐ No ☐ Yes or contacts do not correct?

UCLA New Patient Questionnaire (Cont.)

43. Do you have trouble hearing? ……	☐ No ☐ Yes
44. Do you have pain or difficulty swallowing currently? ……	☐ No ☐ Yes
45. Do you have trouble breathing during your usual activities? ……	☐ No ☐ Yes
46. Have you felt chest pain or chest pressure in the past few months? ……	☐ No ☐ Yes
47. Have you had a cough in the past month? ……	☐ No ☐ Yes
48. Have you had constipation in the past month? ……	☐ No ☐ Yes
49. Have you had diarrhea in the past month? ……	☐ No ☐ Yes
50. Have you seen blood in your stool? ……	☐ No ☐ Yes
51. Have you felt pain in your stomach/abdomen in the past month? ……	☐ No ☐ Yes
52. Have you ever had one or more joints swell? ……..	☐ No ☐ Yes
53. Have you had back pain in the past month? ……	☐ No ☐ Yes
54. Do you have a rash on your body now? ……	☐ No ☐ Yes
55. Have you noticed any mole or growth on your body which is asymmetric, ……. has an irregular border, has changed color, is growing, itches, or bleeds?	☐ No ☐ Yes
56. Have you felt a lump in your breast recently? ……..	☐ No ☐ Yes
57. Have you had a headache in the past three months? ……	☐ No ☐ Yes
58. Do your gums bleed when you brush your teeth? ……..	☐ No ☐ Yes
59. Have you had a nose bleed in the past three months? ……	☐ No ☐ Yes
60. Do you have nasal or ear congestion and/or itching eyes or …… watery eyes on a regular basis?	☐ No ☐ Yes
61. During the past month, have you often been bothered by feeling …… down, depressed, or helpless?	☐ No ☐ Yes
62. During the past month, have you often been bothered by little …….. interest or pleasure in doing things?	☐ No ☐ Yes

HEALTH MAINTENANCE

63. Have you had a tetanus shot (to prevent lockjaw)? ……	☐ No ☐ Yes _____ (yr.)

HEALTH MAINTENANCE (cont.)

64. Have you had an MMR (measles, mumps, rubella shot) or rubella (German measles) shot? ☐ No ☐ Yes _____ (yr.)

65. Have you had chickenpox? ☐ No ☐ Yes

66. Have you had a PAP (cervical) smear? ☐ No ☐ Yes (date of last smear) _____(mo.) _____ (yr.)

67. Have you ever had a abnormal PAP smear? ☐ No ☐ Yes

68. Have you had a mammogram? ☐ No ☐ Yes (date of last mammo.) _____(mo.) _____ (yr.)

69. Have you ever had an abnormal mammogram? ☐ No ☐ Yes

70. Have you ever had a flexible sigmoidoscopy test? (Tube inserted in the rectum to look for colon cancer) ☐ No ☐ Yes (date of last flexible sigmoidoscopy) _____(mo.) _____ (yr.)

71. Have you ever done stool card testing looking for blood? ☐ No ☐ Yes (date of last stool card test) _____(mo.) _____ (yr.)

Patient Signature: _____ Date: _____ Time: _____

Reviewed By: _____M.D. Date Reviewed: _____ Time: _____