TO BE SCANNED

CARTI *New Patient History and Physical Questionnaire*



Patient's Name:_____Today's Date:_____MRN:_____
Gender (Please circle): Male or Female DOB:_____Height:_____Weight:_____
Primary Care Physician:_____ Referring Physician:_____
Other Treating Physicians:_____
What is the main reason for your visit?_____
How long have you had this problem? _____

# Past Medical History:

*Please indicate all applicable medical conditions. Please circle **Yes** or **No** for each condition listed.*

**Vascular**

| | | |
|---|---|---|
| High Blood Pressure | Y | N |
| Heart Attack/Date: | Y | N |
| Heart Rhythm Problems | Y | N |
| Mitral Valve Prolapse | Y | N |
| Congestive Heart Failure | Y | N |
| Cardiac Septal Defects | Y | N |
| Vascular Disease | Y | N |
| Rheumatic Fever | Y | N |
| Stroke or TIA's/Date: | Y | N |
| Anemia | Y | N |
| Deep Vein Thrombosis/Date: | Y | N |
| Other: | Y | N |

**Cancer**

| | | |
|---|---|---|
| **Head and/or Neck/ Date:** | **Y** | **N** |
| **Type:** | | |
| **Skin/Date:** | **Y** | **N** |
| **Lung/Date:** | **Y** | **N** |
| **Colon/Date:** | **Y** | **N** |
| **Prostate/Date:** | **Y** | **N** |
| **Breast/Date:** | **Y** | **N** |
| **Lymphoma/Date:** | **Y** | **N** |
| **Radiation/Date:** | **Y** | **N** |
| **Chemotherapy/Date:** | **Y** | **N** |
| **Other/Type: /Date:** | **Y** | **N** |

**Endocrine**

| | | |
|---|---|---|
| Diabetes Type 1 | Y | N |
| Diabetes Type 2 | Y | N |
| Hypothyroid | Y | N |
| Hyperthyroid | Y | N |

**Autoimmune/Connective Tissue**

| | | |
|---|---|---|
| Rheumatoid Arthritis | Y | N |
| Lupus | Y | N |
| Scleroderma | Y | N |
| Other: | | |

**Respiratory**

| | | |
|---|---|---|
| Sleep Apnea | Y | N |
| CPAP Use | Y | N |
| Pneumonia/Date: | Y | N |
| Asthma | Y | N |
| Home Oxygen | Y | N |

**Gastro-Intestinal**

| | | |
|---|---|---|
| GERD (Reflux) | Y | N |
| Cirrhosis of Liver | Y | N |
| Hepatitis [A] [B] [C] | Y | N |
| Hiatal Hernia | Y | N |
| Ulcers | Y | N |
| Other: | | |

**Renal (Kidney)**

| | | |
|---|---|---|
| Renal Failure | Y | N |
| Kidney Stones | Y | N |
| BPH | Y | N |
| Other: | Y | N |
| | | |

**Gynecologic/Obstetric**

| | |
|---|---|
| Number of Pregnancies | |
| Number of Live Births | |
| Age of menses onset | |
| Age of menopause | |
| Please circle one Surgical or Natural | |

**Other**

| | | |
|---|---|---|
| Glaucoma | Y | N |
| Seizures | Y | N |
| Hearing Loss | Y | N |
| Migraines | Y | N |
| HIV/Aids | Y | N |
| Fibromyalgia | Y | N |
| Other: | | |

## Medications:

Do you take **ANY** medications? **Yes** or **No**

*List all current **prescription** and **over the counter** medications.*

| Medication Name | Dosage/Frequency | Reason for taking this medication. | Start Date |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

**Are you taking any supplements or herbal medications?** **Yes** or **No** *Check all that apply to you.*

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | Vitamin E | | St. John's Wort | | Feverfew | | Vitamin B-12 |
| | Garlic | | Gingko Biloba | | Fish oil/Omega 3 | | Other: |
| | Ginger | | Ginseng | | Multi-Vitamin | | |

*** **Your Preferred Pharmacy**:_____

**Pharmacy address:**_____ **Pharmacy phone:**_____

## Allergies:

*Please check **ALL** allergies you have and **describe your reaction**.*

| | | | |
|---|---|---|---|
| | **None, I have NO allergies** | | Morphine: |
| | Acetaminophen (Tylenol): | | Penicillin: |
| | Aspirin: | | Sulfonamides: |
| | Cephalosporin: | | Tetracycline: |
| | Codeine: | | Benadryl: |
| | Demerol: | | Steroids: |
| | Erythromycin: | | Latex Allergy: |
| | Hydrocodone: | | Shellfish: |
| | Ibuprofen (Advil): | | Other: |
| | Iodine/X-ray dye: | | |
| | | | |

# Past Surgical History:

Have you ever had surgery? **Yes** or **No**

*Please check all that apply to you. For all procedures checked, indicate approximate date.*

### Cardiothoracic

| | |
|---|---|
| | Coronary Artery Bypass/ Date: |
| | Stent Placement/Date: |
| | Pacemaker/Date: |
| | Defibrillator/Date: |
| | Valve Replacement/Date: |
| | Carotid Endarterectomy/Date: |
| | Lung Surgery/Date: |
| | Lobectomy/Date: |
| | Area? |
| | Other: |

### Ear, Nose, Throat

| | |
|---|---|
| | Ear Surgery/Date: |
| | Ear Tubes/Date: |
| | Tonsillectomy/Date: |
| | Adenoidectomy/Date: |
| | Sinus Surgery/Date: |
| | Nasal Surgery/Date: |
| | Tracheal Surgery/Date: |
| | Laryngeal Surgery/Date: |
| | Thyroid Surgery/Date: |
| | Throat Surgery/Date: |
| | Other: |

### Gastroenterology

| | |
|---|---|
| | Gastric Bypass/Date: |
| | Gall Bladder/Date: |
| | Hiatal Hernia Repair/Date: |
| | Appendectomy/Date: |
| | Colectomy/Date: |
| | Other: |

### Other Surgery

| | |
|---|---|
| | Craniotomy/Date: |
| | Cancer Surgery/Date: |
| | Tubal Ligation/Date: |
| | Hysterectomy/Date: |
| | EGD/Date: |
| | Aortic Aneurysm/Date: |
| | Mastectomy/Date:<br>Left, Right, or Bilateral? |
| | Lumpectomy/Date:<br>Left, Right, or Bilateral? |
| | Other: |
| | |

### Orthopedic

| | |
|---|---|
| | Knee Replacement/Date: |
| | Hip Replacement/Date: |
| | Neck/Spine Surgery/Date: |
| | Back Surgery/Date: |
| | Other: |

| |
|---|
| Additional Information regarding Surgical History: |

****** Please be sure to indicate ALL prosthetics and surgical implants.**

# Immunization History:

*Please circle **Yes** or **No** and explain for each that is applicable.*

| Vaccination received | | | Date of vaccination. |
|---|---|---|---|
| Influenza (flu shot) | Y | N | |
| Pneumovax | Y | N | |
| Varicella (Herpes Zoster, Chickenpox) | Y | N | |
| Hepatitis [A] [B] | Y | N | |
| Other: | Y | N | |

# Health Maintenance:

*Please circle **Yes** or **No** and explain for each that is applicable.*

| | | |
|---|---|---|
| Y | N | Have you ever had previous problems with ANESTHESIA? Describe: |
| | | |
| Y | N | Do you BRUISE or BLEED excessively when cut? Describe: |
| | | |
| Y | N | Have you ever had a SLEEP STUDY? Most recent date tested: |
| | | Results? |
| Y | N | Have you ever had a COLONOSCOPY? Most recent date tested: |
| | | Results? |
| Y | N | Have you ever had an EGD? Most recent date tested: |
| | | Results? |
| Y | N | Have you ever had a MAMMOGRAM? Most recent date tested: |
| | | Results? |
| Y | N | Have you ever had a PAP SMEAR? Most recent date tested: |
| | | Results? |

# Family History: *Check which statement applies to you.*

**Family History of Cancer or Blood Disorder: _____** **Family History Unknown _____**

*If you have family history of cancer: List relationship, cancer type or blood disorder, age at diagnosis, age at death and cause of death if applicable).*

| Relationship | Cancer type or blood disorder | Age at diagnosis | Age at death |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

# Histories and Risk Factors:

| | | |
|---|---|---|
| **Alcohol** | Do you use alcohol? Please circle Yes or No<br>How many drinks per week? _____<br>What type of alcohol? _____ | |
| **Tobacco** | •Current every day smoker? Yes or No<br>Age you started? _____<br>•Current occasional smoker? Yes or No<br>•Former Smoker? Yes or No<br>•Age you quit? _____<br>•Never Smoked _____<br>•Have you had smoking cessation counseling?<br>Yes or No | Packs/day? _____<br><br>Tobacco type used:<br>____Cigarettes<br>____Cigars<br>____Pipe<br>____Smokeless Tobacco<br>____E-Cigarettes<br>____Vapor |
| **Drugs** | •Do you currently use recreational or street drugs?<br>(marijuana, cocaine, heroin, amphetamines, etc.)<br>Yes or No<br>•Have you used drugs in the past? Yes or No<br>•What drugs have you used in the past?_____<br>_____<br>•Have you ever given yourself street drugs with a needle?<br>(Intravenous drugs)? Yes or No | |
| **Social Support** | • Local family or friends available for support?<br>Yes or No | Please list:_____<br>_____<br>_____<br>_____ |
| **Diet** | •Are you on a special diet? Yes or No<br><br>•If yes, please explain:<br>Diabetic diet?<br>Cardiac diet?<br>Soft foods?<br>Other? | |
| **Exercise** | •Do you exercise? Yes or No<br>•How often do you exercise? _____<br>•What type of exercise? _____ | |
| **Work & Education** | •Do you work? Yes or No<br>•What type of work do you do? (type of occupation)<br>_____<br>•Are you retired? Yes or No<br>•Are you on disability? Yes or No<br>Reason for disability?_____<br>• What is your education level? (Circle One)<br>Grade School<br>High School<br>Vocational School<br>College<br>Graduate School | |

# Review of Systems:

*Please circle **Yes** or **No** for each condition listed.*

**General**

| | | |
|---|---|---|
| Fatigue | Y | N |
| Low Energy Level | Y | N |
| Fever | Y | N |
| Chills | Y | N |
| Pain | Y | N |
| Weight Gain | Y | N |
| Weight Loss | Y | N |
| Loss of Appetite | Y | N |

**Eyes**

| | | |
|---|---|---|
| Double Vision | Y | N |
| Excessive Tearing | Y | N |
| Impaired Vision | Y | N |
| Redness | Y | N |
| Light Sensitivity | Y | N |

**Skin**

| | | |
|---|---|---|
| Nodules | Y | N |
| Rash | Y | N |
| Dry Skin | Y | N |
| Radiation Therapy Effect | Y | N |
| Nail Changes | Y | N |

**Breast**

| | | |
|---|---|---|
| Breast Mass | Y | N |
| Breast Pain | Y | N |
| Nipple Discharge | Y | N |

**Neurologic**

| | | |
|---|---|---|
| Abnormal Gait | Y | N |
| Confusion | Y | N |
| Dizziness | Y | N |
| Headache | Y | N |
| Memory Loss | Y | N |
| Numbness & Tingling | Y | N |
| Paralysis | Y | N |
| Seizures | Y | N |

**Cardiovascular**

| | | |
|---|---|---|
| Difficulty breathing while lying down | Y | N |
| Fainting or lightheadedness | Y | N |
| Chest Pain | Y | N |
| Heart Racing | Y | N |
| Swelling (legs or feet) | Y | N |

**Respiratory**

| | | |
|---|---|---|
| Cough | Y | N |
| Coughing up Blood | Y | N |
| Shortness of Breath | Y | N |
| Cough with Sputum | Y | N |
| Wheezing | Y | N |
| Pain with Breathing | Y | N |

**Ear/Nose/Throat**

| | | |
|---|---|---|
| Earache | Y | N |
| Nose Bleeds | Y | N |
| Hoarseness | Y | N |
| Sore Throat | Y | N |
| Difficulty Swallowing | Y | N |
| Mouth Sores | Y | N |
| Dry Mouth | Y | N |
| Altered Taste | Y | N |
| Balance Issues | Y | N |
| Loss of Hearing | Y | N |
| Ringing in Ears | Y | N |
| Congestion | Y | N |
| Bleeding Gums | Y | N |

**Gastroenterology**

| | | |
|---|---|---|
| Abdominal Cramping | Y | N |
| Changes in Bowel Habits | Y | N |
| Constipation | Y | N |
| Diarrhea | Y | N |
| Dark/Black Stools | Y | N |
| Nausea | Y | N |
| Vomiting | Y | N |
| Heartburn | Y | N |
| | | |
| Jaundice | Y | N |

**Hematology**

| | | |
|---|---|---|
| Prolonged Bleeding | Y | N |
| Painful Lymph Nodes | Y | N |
| Easy Bruising | Y | N |
| Swollen Glands | Y | N |

**Psychiatric**

| | | |
|---|---|---|
| Anxiety | Y | N |
| Depression | Y | N |
| Insomnia | Y | N |
| Poor Concentration | Y | N |
| Mood Swings | Y | N |

**Endocrine**

| | | |
|---|---|---|
| Cold Intolerance | Y | N |
| Heat Intolerance | Y | N |
| Increased Sweating | Y | N |
| Excessive Thirst | Y | N |

**Gynecologic**

| | | |
|---|---|---|
| Abnormal Menstrual Periods | Y | N |
| Abnormal Vaginal Bleeding | Y | N |
| Vaginal Discharge | Y | N |
| Pelvic Pain | Y | N |
| Sexual Dysfunction | Y | N |
| Vaginal Dryness | Y | N |

**Musculoskeletal**

| | | |
|---|---|---|
| Joint Pain | Y | N |
| Joint Stiffness | Y | N |
| Back Pain | Y | N |
| Bone Pain | Y | N |
| Muscle Pain/Weakness | Y | N |

**Genitourinary**

| | | |
|---|---|---|
| Burning on Urination | Y | N |
| Blood in Urine | Y | N |
| Increased Urination | Y | N |
| Urinary Hesitancy | Y | N |

**Allergy/Immunology**

| | | |
|---|---|---|
| Eczema | Y | N |
| Frequent Infections | Y | N |
| Respiratory Infections | Y | N |
| Seasonal Allergies | Y | N |

Patient's Signature:_____ Date: _____

Physician's Signature:_____ Date: _____