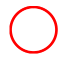
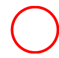
Staple

NewYork-Presbyterian
The University Hospital of Columbia and Cornell

51158

PATIENT QUESTIONNAIRE

IF NO PLATE, PRINT NAME, SEX AND MEDICAL RECORD NO.

Name: ______________________________ Date: _____/_____/______

Review of Systems

Doctor's Comments

Have you noticed any change in your:

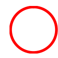
Weight	YES	NO	______
Appetite	YES	NO	______
Energy Level	YES	NO	______

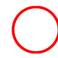
Do you have any of the following:

Fever	YES	NO	______
Headaches	YES	NO	______
Blurred / Double Vision	YES	NO	______
Earache	YES	NO	______
Ringing in ears	YES	NO	______
Hearing Loss	YES	NO	______
Nose Bleeds	YES	NO	______
Nasal Stuffiness	YES	NO	______
Sore Throat	YES	NO	______
Hoarseness	YES	NO	______
Dry Mouth	YES	NO	______
Difficulty / Pain opening your mouth	YES	NO	______
Difficulty / Pain Swallowing	YES	NO	______
Shortness of Breath	YES	NO	______
Blood in Sputum	YES	NO	______
Cough	YES	NO	______
Chest Pain	YES	NO	______
Palpitations	YES	NO	______

51158 (12/05)

Staple





NewYork-Presbyterian
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PATIENT QUESTIONNAIRE

IF NO PLATE, PRINT NAME, SEX AND MEDICAL RECORD NO.

Patient Questionnaire

Heartburn	YES	NO	______
Abdominal Pain / Cramps	YES	NO	______
Nausea / Vomiting	YES	NO	______
Diarrhea	YES	NO	______
Constipation	YES	NO	______
Blood in Stool	YES	NO	______
Blood in Urine	YES	NO	______
Breast Lumps	YES	NO	______
Nipple Discharge	YES	NO	______
Vaginal Discharge	YES	NO	______
Vaginal Bleeding	YES	NO	______
Frequent Urination	YES	NO	______
Incontinence	YES	NO	______
Burning on Urination	YES	NO	______
Difficulty / Unable to have an erection	YES	NO	______
Skin Rashes	YES	NO	______
Easy Bruising	YES	NO	______
Jaundice	YES	NO	______
Itching	YES	NO	______
Numbness / Weakness in arms or legs	YES	NO	______
“Pins & Needles” sensations in arms or legs	YES	NO	______
Fatigue	YES	NO	______
Muscle, Joint, Bone Pain	YES	NO	______
Seizures	YES	NO	______
Loss of Balance	YES	NO	______
Nervousness	YES	NO	______

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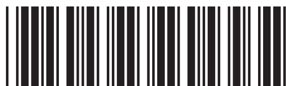

PATIENT QUESTIONNAIRE

IF NO PLATE, PRINT NAME, SEX AND MEDICAL RECORD NO.

Patient Questionnaire

Depression	YES	NO	______
Enlarged Lymph Nodes	YES	NO	______

Do you have / or had:

Diabetes	YES	NO	______
High Blood Pressure	YES	NO	______
Heart Problems	YES	NO	______
Liver Disease	YES	NO	______
Kidney Problems	YES	NO	______
Hemorrhoids	YES	NO	______
Diverticulosis / Colitis	YES	NO	______

Past, Family, Social History:

Do you have any allergies? ______
Are you allergic to any medications or shell fish? ______
If so, please list them here: ______

Please list your current medications (including vitamins, aspirin, & other pain medications):

______

______

Have you had any surgery in the past? If so, please list them here: ______

______

______

Have you ever had radiotherapy?
If yes, when?______ YES NO

Have you ever had chemotherapy?
If yes, when? ______ YES NO

Have any of your family members had cancer?

Mother	YES	NO	Type: ______
Father	YES	NO	Type: ______

Patient Questionnaire

Mother YES NO Type: ______________________________

Father YES NO Type: ______________________________

Do you / Have you ever smoked? YES NO

If so, on average, how many cigarettes do you smoke every day? ______________

And for how Long? ______________________________

Do you drink alcohol? YES NO

If so, on average, how many drinks do you have daily? ______________

Have you ever used recreational drugs? YES NO

If yes what kind? ______________________________

I have reviewed and confirmed the above patient history.

______________________ MD
Resident Signature

______________________ MD
Attending Signature

____
Print Resident Name / ID Code

____
Print Attending Name / ID Code