Rizwan U. Hassan, M.D.
3243 E. Murdock Suite 104, Wichita, KS 67208

New Patient Questionnaire

FULL NAME: _____DATE:_____

DOB: _____AGE:_____SEX:_____HEIGHT:_____WEIGHT:_____

What is your current problem that you are here for now? _____
_____

Do you have a Living Will? Yes_____ No_____ (Advanced Care Plan).

1. Past Medical History: List all operations and approximately when they were done._____

_____

_____

_____

Do you have now, or have you ever had any of the following?

	Yes	When	No		Yes	When	No
High blood pressure	_____	_____	_____	Stroke	_____	_____	_____
Heart Attack	_____	_____	_____	Seizures	_____	_____	_____
Rheumatic Fever	_____	_____	_____	Depression	_____	_____	_____
Asthma	_____	_____	_____	Syphilis	_____	_____	_____
Tuberculosis	_____	_____	_____	Meningitis	_____	_____	_____
Diabetes Mellitus	_____	_____	_____	Encephalitis	_____	_____	_____
Cancer	_____	_____	_____	Head Injuries	_____	_____	_____
Arthritis	_____	_____	_____	Broken Bones	_____	_____	_____
Serious Injuries	_____	_____	_____				

Do you have any other medical problems not listed above? _____
_____.

2. List <u>ALL</u> Medications (including aspirin, birth control, vitamins) you are currently taking.

Medication Strength how often do you take it?

_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____

3. **List <u>ALL</u> Medication (including x-ray dye) that you are *<u>ALLERGIC</u>* to*:***

_____ _____ _____
_____ _____ _____

Occupation: _____Employer_____

Patient Name_____

4. Social History:

Martial Status: Single___ Married___ Widowed___ Divorced___ # of Children____

Do you smoke now or did you smoke in the past? ___Yes ___No How many cigarettes a day? _____ How may years of smoking? _____ What year did you stop smoking? ___

Do you drink alcohol? ____Yes _____No If yes, how much and what type_____

Do you exercise? _____

5. Family History:

Do you have any family members, living or dead, (parents, siblings) have any of the following disease?

Stroke_____ Migraine Headaches_____
Epilepsy_____ Anemia_____
Cancer_____ Diabetes Mellitus_____
Thyroid Problems_____ Cirrhosis of the liver_____
Heart Problems_____

6. Are you having trouble with any of the following:

	Yes	No		Yes	No
Headaches	___	___	Bloody Stools	___	___
Dizziness	___	___	Black, tarry stools	___	___
Double Vision	___	___	Stomach pain	___	___
Seizures	___	___	Losing bowl control	___	___
Tremors	___	___	Bloody urine	___	___
Fainting Spells	___	___	Cloudy urine	___	___
Numbness	___	___	Pain w/urination	___	___
Tingling	___	___	Trouble starting urination	___	___
Weakness	___	___	losing control of bladder	___	___
Cough	___	___	Heat intolerance	___	___
Shortness of Breath	___	___	Cold intolerance	___	___
Chest Pain	___	___	Bruising	___	___
Heart Flutter/Racing	___	___	Bleeding	___	___
Swelling of extremities	___	___	recurrent infections	___	___
Nausea	___	___	Fatigue	___	___
Vomiting	___	___	Itching	___	___
Food intolerance	___	___	Fever	___	___
Weight loss	___	___	Chills	___	___
Diarrhea	___	___	Muscle Pain	___	___
Constipation	___	___	Joint Pain	___	___

Please List your Primary Care Physician_____Telephone_____

Please List Referring Physician_____Telephone_____