UCLA Center for East-West Medicine

NEW PATIENT QUESTIONNAIRE

MRN:
Patient Name:

(Patient Label)

Welcome to the UCLA Center for East-West Medicine Primary Care

Please take your time with the paper work and provide it to your doctor for the visit

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Visit expectations:

Who are the other health care practitioners you see? *Example: acupuncturists, therapists, specialists…*

What were you hoping to discuss today (Rank by priority):

1)____

2)____

3)____

Are there any specific things you were hoping to receive from your visit? *Examples: Prescriptions, immunizations, blood tests, referrals.*

Medical/Surgical History:

List any of your medical conditions that were diagnosed by a doctor:

List any significant surgical or medical procedures you have had in the past:

Family History: Please check any disease that run in your family:

Heart Disease		High Blood Pressure		Diabetes		Stroke	
Autoimmune Rheumatologic		Dementia		Depression/Anxiety		High Cholesterol	
Osteoporosis		Breast Cancer		Colon Cancer		Other	

Medications: Please list all medications, herbs, supplements, vitamins or over the counter products that you are using REGULARLY: *(If you have a list, please provide to the medical assistant)*

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Health Goals:

Feeling well is central to a productive and active life. Please take some time to think of three well-being goals you have for yourself. We will work as a team to help you achieve these goals.
Examples of goals: 1) Decrease my knee pain so that I can walk daily; 2) Lose weight; 3) try to decrease the number of medications I take every morning.

1)____
2)____
3)____

How committed are you to address the underlying issues affecting your overall health?

(Not committed) 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10 (Extremely committed)

Mood: Over the last TWO weeks, how often have you noticed the following?

	Not at all	Several Days	Greater than half days	Nearly every day
Little interest in doing things				
Feeling down or depressed				
Feeling nervous, anxious or on edge				
Being unable to stop or control worrying				

Personal History:

What do you do for work? ____

Whom do you live with? ____

Relationship Status (circle): Single – Married – Divorced – Widowed - Domestic Partner - Other

Do you have children? Yes / No -- If yes, how many? ____________

Substance Use History:

How often do you USE any of the following? (check all that apply)

☐ Tobacco? (If yes, how many years and packs per day)

____

Did you previously quit? Yes / No If yes, what year? ____________

☐ Alcohol? If yes, drinks per week ____________

☐ Marijuana? ____________

☐ Other? ______________

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Sex and Safety:

Do you have any concerns about your sexual activity or function? Yes ☐ No ☐

In the past 12 months, have you been hurt or felt threatened by someone close to you? Yes ☐ No ☐

Sleep:

How would you rate the quality of your sleep? Please circle.

(Terrible) 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10 (Completely Restful)

Do you snore? Or have been told you snore or that you stop breathing during sleep? Yes ☐ No ☐

Do you often feel TIRED, fatigued, or sleepy during daytime? Yes ☐ No ☐

Exercise and Nutrition/Weight:

What do you do for **exercise**?

Do you have any questions or concerns about diet, nutrition or your weight? Yes ☐ No ☐

If yes, what are they?

What did you eat and drink yesterday?

Breakfast	Lunch	Dinner	Snacks	Drinks

Stress: Everyone has stress.

1. From where does your MAJOR life stress come (work, home, etc)?

2. What do you do to relax, cope and let go?

3. Please rate the stress you have been feeling lately on a scale from 0 – 10: Please circle.

(No stress) 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10 (Terrible stress)

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(Patient Label)

Immunization and Health Screening History:

RECOMMENDED for EVERYONE:	AGE SPECIFIC:
What YEAR was your last vaccination? Influenza : __________ (Due yearly) Tetanus : __________(Due every 10 years) **Past vaccination or disease?** Varicella/Chicken Pox Yes ☐ No ☐ Measles/Mumps/Rubella: Yes ☐ No ☐	**Did you get these vaccinations previously?** Less than Age 27 - Gardasil [HPV]: Yes ☐ No ☐ Age 50 & Over – Shingrix [shingles]: Yes ☐ No ☐ Age 60 & Over - Zostavax [shingles]: Yes ☐ No ☐ Age 65 & Over - Pneumovax [pneumonia]: Yes ☐ No ☐ Prevnar [pneumonia]: Yes ☐ No ☐

WOMEN: Year of your last:	MEN:	MEN & WOMEN: Year of your last:
Pap Smear: ____________ Mammogram: ___________ Bone Density: ____________	Prior PSA testing? Yes ☐ No ☐	Colonoscopy/stool test? ___________ (Due age 50) Visit to the dentist? _______________

Review of Systems: Have you been experiencing any of the following recently?

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General:	☐ Fever/Chills	☐ Night Sweats	☐ Severe Fatigue
	☐ Unintended Weight Changes		
Eyes:	☐ Sudden Vision Change	☐ Dryness	
Ears:	☐ Hearing Changes	☐ Vertigo	☐ Ringing
Nose, mouth, throat:	☐ Nasal Congestion	☐ Hoarseness	☐ Sore Throat
	☐ Sores	☐ Trouble Swallowing	
Cardiovascular:	☐ Lightheadedness	☐ Chest pain/Angina	☐ Leg Swelling
	☐ Palpitations		
Respiratory:	☐ Chronic Cough	☐ Wheezing	☐ Shortness of Breath
Gastrointestinal:	☐ Abdominal Pain	☐ Nausea/Vomiting	☐ Diarrhea
	☐ Bloody Stool	☐ Heartburn	☐ Constipation
Genitourinary:	☐ Burning Urination	☐ Bloody Urine	☐ Incontinence
Women:	☐ Vaginal Discharge	☐ Painful Periods	☐ Heavy Periods
Men:	☐ Testicular Pain	☐ Penile Discharge	☐ Abnormal Urine Flow
Musculoskeletal:	☐ Back Pain	☐ Joint Pain	
Skin:	☐ Rash	☐ Severe Hair loss	☐ New or Changing Moles
Neurologic:	☐ Numbness/Tingling	☐ Weakness	☐ Frequent Headaches
	☐ Memory Loss	☐ Imbalance	
Psychiatric:	☐ Anxiety	☐ Depression	
Endocrine:	☐ Increased Hunger	☐ Increased Thirst	☐ Heat or Cold Intolerance
Hematologic:	☐ Easy Bleeding	☐ Swollen Lymph Nodes	
Allergic:	☐ Hives	☐ Frequent Infections	

Patient or Representative Signature __________________________ Date _______