Northwell General and GI Surgery

New Patient Questionnaire:

Please complete this questionnaire and bring it with you to your appointment with the practitioner. This information will assist us in your care plan. Thank you.

Full Name: _____ **Date of Birth:** _____

Gender: Female Male

Address: _____

City, State, Zip: _____

Home Phone: _____ Work Phone:_____

Cell Phone: _____

Email: _____

Race: (please circle all that apply)

African-American Asian Caucasian Hispanic Pacific Islander/Hawaiian

Native American Other:_____

What are you here for today? _____

Surgeon Requested (if known): _____

Hospital Requested (if known): _____

How did you hear about our program? ☐ My physician _____ ☐ A friend _____

☐ Facebook ☐ Internet ☐ Northwell's Website ☐ Brochure ☐ Newspaper ☐ Other _____

Primary Care/Family Physician: _____

Practice Name: _____

Address: _____City, State, Zip: _____

Office Phone: _____Office Fax:_____

Referring Physician (if different from above): _____

Practice Name: _____

Address: _____City, State, Zip: _____

Office Phone: _____Office Fax:_____

Please indicate if you **are now experiencing or in the past year experienced** any of the symptoms listed below.

GENERAL

___ Weight Gain
___ Weight Loss
___ Fever
___ Chills
___ Night Sweats
___ Fatigue

HEAD, EARS, EYES, NOSE, THROAT

_____ Eye Pain
_____ Red Eyes
_____ Dry Eyes
_____ Vision Problems
_____ Trouble Swallowing
_____ Pain with Swallowing
_____ Hearing Loss
_____ Nose Bleeds
_____ Dry Mouth
_____ Sore Throat
_____ Hoarseness
____ Swollen Nodes

CARDIO-VASCULAR

_____ Chest Pain
_____ Palpitations
_____ Light Headedness
_____ Leg pain with exercise
_____ Leg swelling

RESPIRATORY

_____ Shortness of Breath
____ Wheezing
____ Cough
____ Painful Breathing
____ Shortness of breath With activity
____ Sleep Apnea

GASTRO-INTESTINAL

_____ Abdominal Pain
____ Heartburn/Reflux
____ Nausea/Vomiting
____ Hernia
____ Constipation
____ Diarrhea

RENAL/REPRODUCTIVE

____ Painful Urination
____ incontinence
____ Vaginal Discharge
____ Abnormal Vaginal Bleeding

MUSCULOSKELETAL

____ Joint Pain
____ Joint Stiffness
____ Back Pain
____ Muscle Pain
_____ Muscle Weakness

SKIN

____ Rashes
____ Skin wound

NEUROLOGIC

____ Confusion
_____ Dizziness
____ Fainting
____ Difficulty walking

PSYCH

____ Suicidal
____ Insomnia
____ Anxiety
_____ Depression

ENDOCRINE

_____ Bulging eyes
____ Hot Flashes
____ Muscle Weakness
____ Voice Change

HEME

____ Easy Bleeding
____ Easy Bruising
____ Swollen Glands

Medical History: Please indicate if you have been diagnosed with any of the following illnesses:

_____ Heart Attack
_____ Cardiac Failure
_____ Coronary Disease
_____ High Blood Pressure
_____ High Cholesterol
_____ High triglycerides
_____ Obesity
_____ Constipation

_____ COPD (lung disease)
_____ Asthma
_____ Sleep Apnea
_____ Emphysema
_____ Reflux/GERD
_____ Stomach ulcers
_____ Hiatal Hernia
_____ Abdominal Hernia
_____ Swallowing trouble

_____ Achalasia
_____ Small Bowel Obstruction
_____ Hypothyroid
_____ Hyperthyroid
_____ Type 1 Diabetes
_____ Type 2 Diabetes
_____ Autoimmune Disease

_____ Epilepsy/Seizures
_____ Neurological Disease
_____ Depression
_____ Anxiety
_____ Arthritis
_____ Cancer Type:_____

Please indicate any other illnesses or medical history:

_____

Surgical History

Please indicate any previous surgeries:

_____

_____

Do you have pain that interferes with your daily activity? No Yes

If yes, where is the pain? _____

Please circle the number that represents your pain level:

No pain 0 1 2 3 4 5 6 7 8 9 10 Severe pain

Social History

Employment Status: Full Time Part Time Self Employed Retired Unemployed
Homemaker Student Disabled Not Specified

Occupation: _____ Employer:_____

Marital Status (please circle one): Single Married Separated Divorced Widowed Partnered
Do you have children/how many? _____

Do you use?		**If YES, how much/often?**
Tobacco/Nicotine products ***(cigarettes, pipes, cigars, chewing tobacco, e cigarettes, vapes, nicotine patches/gums/lozenges, Chantix)***	**YES** **NO**	**_____ packs per day for _____ years** **If you quit, when? _____**
Alcohol	**YES** **NO**	**Type: _____** **Frequency:_____**
Recreational Drugs **(*opioids, marijuana, cocaine, heroin, etc.)***	**YES** **NO**	**Type: _____** **Frequency:_____**

Medications and Supplements:

Medication/Supplement	Dosage & Frequency	Reason

Allergies

Medication/Food	**Reaction**
Other Allergies	**Reaction**

Do you exercise regularly? □ Yes □ No
Types of exercise? □ Strengthening □ Cardio Other:_____
How often?_____ times/week _____times/month
If no, what prevents you from exercising? Time Work Health Other: _____

COVID Status

Have you had COVID? □ Yes (Date):_____ □ No
Have you been vaccinated for COVID? □ Yes (Date):_____ □ No

Family History

Please specify if you have any family members with:

Obesity _____
Heart Disease _____
Diabetes/Endocrine _____
High Blood Pressure _____
Cancer _____Type: _____
Arthritis _____
Early Death _____
Asthma _____
Stroke _____
Depression _____
Other Diseases _____