HMG Geriatric Medicine
Dr. Ronna New
New Patient Questionnaire

Name:_____ Date:_____

Address:_____ Date of Birth:_____
_____ Chart#:_____

Person Completing Form (if not patient):_____
Relationship to Patient:_____

Were you referred to Dr. Ronna New by another physician/provider? Yes No
If so, who referred you?_____

Do you have a primary care physician? Yes No
If so, who is your primary care physician?_____

How did you learn about HMG Geriatric Medicine-Dr. Ronna New?_____
_____

Describe the reason for today's office visit:_____
_____
_____
_____
_____

Current Prescribed Medications (dose and how often):
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Over-the-Counter Medications/Nonprescription Medications (dose and how often):
_____
_____

Vitamins & Mineral Supplements/Herbals (dose and how often):
_____
_____

Allergies (please include type of reaction):

_____

_____

Past Medical History (check any that apply):

____Asthma
____COPD
____Emphysema
____Bronchitis
____Pneumonia
____Pulmonary Embolism
____Allergies/Hay Fever
____Tuberculosis
____High Blood Pressure
____High Cholesterol/Lipids
____Heart Attack (MI)
____Heart Failure (CHF)
____Heart Murmur
____Rheumatic Fever
____Atrial Fibrillation (A-Fib)
____Pacemaker
____Stroke (CVA/TIA)
____Deep Venous Thrombosis-DVT

____Anemia
____Hypothyroidism
____Other Thyroid Disease
____Osteoporosis
____Arthritis
____ Gout
____ Liver Disease/Cirrhosis
____Hepatitis
____HIV/AIDS
____Reflux (GERD)
____Gastric/Stomach/Peptic Ulcer
____Diverticulosis/Diverticulitis
____Kidney Disease
____Urinary Incontinence
____Prostate Problems
____Cancer: Type?_____
____Depression
____Anxiety

____Cataracts
____Macular Degeneration
____Glaucoma
____Vision Problem
____Hearing Problem
____Dementia
____Memory Problems
____Seizure
____Parkinson's Disease

Other Medical Condition(s):

_____

_____

Surgeries/Hospitalizations/Major Illnesses:

Reason	**Date**

Family History (please list any medical problems of your family as below):

Family Member	**Medical Problems/Illnesses**
Mother	
Father	
Sisters	
Brothers	
Other	

Social History:

Place of birth:_____ Occupation:_____
Where did you grow up?_____ Highest Education Level:_____
Marital Status:_____Children:_____
_____
Please list anyone who lives in your home:_____
_____
Do you currently smoke or chew tobacco? Yes No If no, did you previously? Yes No
How many years?_____ How many packs per day?_____

Do you currently drink alcohol? Yes No If no, did you previously? Yes No
How many years?_____ How many drinks per day?_____

Do you use or have you ever used illicit drugs/substances? Yes No

Do you exercise? Yes No How often?_____
What exercise activity do you do?_____

Are you currently sexually active? Yes No

Do you have any history of physical or sexual abuse? Yes No

Advance Directive/Living Will/Durable Medical POA:

Do you have an advance directive/living will? Yes No
Do you have a durable medical power of attorney? Yes No
If so, who is your durable medical power of attorney?_____
Durable medical power of attorney's relationship to patient:_____
Contact Information for durable medical power of attorney:
Phone:_____
Address:_____
***Please provide a copy of your advance directive/living will.**

Activities of Daily Living/Instrumental Activities of Daily Living:

Are you able to feed yourself? Yes No
Are you able to dress yourself? Yes No
Are you able to bathe yourself? Yes No
Are you able to walk without assistance? Yes No
Do you use a cane/walker/wheelchair? Yes No
What do you use? Cane Walker Wheelchair Other:_____

Are you able to manage your own medications? Yes No
Do you drive? Yes No
Do you manage your own finances? Yes No
Do you cook and/or do housework? Yes No

Do you need assistance from someone else for any of the above? Yes No
If so, who helps you?_____