Phone: (601) 707-3490 Fax: (601) 707-3491
1067 Highland Colony Parkway Suite G, Ridgeland, MS 39157

NEW PATIENT QUESTIONNAIRE

Name: ____ DOB: ___________________

Referring Physician (IF DIFFERENT): ____

Pharmacy: _____________________________________ Phone #:________________________

Address: ____

What is the reason for your visit today (please include any symptoms you have)?

____

Current Medications: (please make sure you bring **ALL** medications with you to your appointments)

Please list **ALL** medications (prescription and non-prescription) that you currently take. If you need additional space, please list them on the back of this page:

Medication Name	Dosage	How often do you take it	Prescribed by
________________________	__________	________________________	____________________
________________________	__________	________________________	____________________
________________________	__________	________________________	____________________
________________________	__________	________________________	____________________
________________________	__________	________________________	____________________
________________________	__________	________________________	____________________
________________________	__________	________________________	____________________

Allergies: Do you have Allergies to Iodine, seafood or radiographic contrast dye? Yes/ No

Please list **ALL** allergies and describe the reaction to them:

Allergy:	Reaction:
_________________________________	____
_________________________________	____
_________________________________	____

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Social History: Please answer **ALL** questions.

Occupation: ________________________ Number of children: __________________________

Do you currently smoke? Yes/ No If yes, how much? ________ How long? ________

Have you ever smoked? Yes/ No Do you currently use smokeless tobacco? Yes /No

Do you drink alcohol? Yes/ No If yes, how much? ________ How long? ________

Have you ever used illicit drugs? Yes/ No If yes, what kind? _________ How long? ________

Do you currently use illicit drugs? Yes/ No If yes, what kind? _________ How long? ________

Do you exercise? Yes/ No If yes, how often? _________

How much caffeine (coffee, tea, soft drinks) do you drink daily? __________________________

Please circle: Married Single Divorced Widowed Separated

Family History: Please answer **ALL** question as they apply to your mother, father, siblings, and children.

Any history of the following:

Heart Disease? Y/ N Whom: _____________ Stroke? Y/N Whom: ___________________

Cancer? Y/N Whom: ____________________ Diabetes? Y/N Whom: ________________

High Blood Pressure? Y/N Whom: ____

Past Surgical History: Please list **ALL** prior surgeries:

Surgery:	Date:	Physician:
___________________________________	______________________	___________________
___________________________________	______________________	___________________
___________________________________	______________________	___________________
___________________________________	______________________	___________________

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Past Medical History: Please answer **ALL** questions.

Do you have any of the following cardiac risk factors? (please circle yes or no)

Hypertension (high blood pressure): Yes/ No Diabetes: Yes/ No

History of smoking/ current smoker: Yes/ No High cholesterol: Yes/ No

Do **you** personally have a history of the following:	Yes	No	Details (e.g., dates, hospitals, treating physicians)
Known coronary artery disease?			
heart attack requiring hospitalization			
coronary artery stenting			
coronary artery ballooning only			
coronary artery bypass surgery			
Heart rhythm disorders?			
Pacemaker			
Defibrillator (ICD)			
Atrial fibrillation			
Atrial flutter			
Ventricular arrhythmias			
Cardioversion			
Ablation procedure			
Heart Failure?			
A heart murmur?			
Mitral valve prolapse?			
Rheumatic heart disease?			
High blood pressure (even if treated)?			
High cholesterol (even if treated)?			
Diabetes (even if treated)?			
Stroke?			
Black out or Fainting spell?			
Aortic aneurysm (enlarged aorta)?			
Thyroid disorder? Explain			
Asthma/ Emphysema/ COPD?			
Stomach/ peptic ulcers?			
Gastrointestinal bleeding?			
Heartburn/ Reflux (GERD)?			
Lung cancer?			
Colon cancer?			
Breast cancer?			
Prostate cancer?			
History of a blood clot? (DVE/PE)			
Bleeding disorder?			

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Review of Systems: Please indicate if you are **CURRENTLY** experiencing any of the following:

How many flights of stairs can you climb without stopping? __________

How many pillows do you sleep on at night? _________

	YES	NO	PAST
CONSTITUTIONAL			
Recent change in weight			
Unexplained Fever			
Chills			
Night Sweats			
Decreased appetite			
Fatigue			
Inability to sleep			
EYES			
Recent change in vision			
Blurred/Double vision			
Eye pain			
Wear glasses/contacts			
Cataracts			
Glaucoma			
EARS/ NOSE/ MOUTH/ THROAT			
Dry Mouth			
GASTROINTESTINAL			
Nausea			
Vomiting			
Abdominal pain			
Diarrhea			
Constipation			
Heartburn/ reflux			
Blood in stool			
CARDIOVASCULAR			
Chest pains			
Palpitations			
Inability to sleep lying flat			
Swelling in the legs or feet			
Muscle pains while walking			
Awakening short of breath			
Lightheadedness			
Loss of consciousness			
Decreasing exercise tolerance			
RESPIRATORY			
Shortness of breath			
Coughing up phlegm			
Coughing up blood			
Wheezing			

	YES	NO	PAST
MUSCULOSKELETAL			
Pains in joints			
Muscle pain			
Bone fractures			
Pain in the bones			
GENITOURINARY			
Urination frequently			
Urinate suddenly			
Increase urination at night			
Blood in urine			
Pain while urinating			
Urinary incontinence			
DERMATOLOGICAL			
Rashes			
Ulcers			
Hair loss			
Change in skin			
ENDOCRINOLOGIC			
Intolerance to heat			
Intolerance to cold			
Increased need for fluids			
HEMATOLOGICAL			
Easy bleeding			
Easy bruising			
Swollen glands			
Swollen lymph nodes			
ALLERGIC/ IMMUNOLOGIC			
Diffuse itching			
Anaphylaxis			
Swelling of the throat			
PSYCHIATRIC			
Depressed mood			
Inability to enjoy anything			
Anxiety			
Suicidal thoughts			
Hallucinations			
Stress			
NEUROLOGICAL			
Weakness of arm/leg			
Severe headaches			
Memory loss			
Seizures			
Sensation of world spinning			