MED LYFE FIT

New Patient Questionnaire

Please complete all 5 pages, sign and date the last page.

PLEASE be sure to put your name & date of birth on each page as they may become separate before scanning.

Med-Life-Fit Family Practice
10000 Brownsboro Rd, Suite 7
Louisville, KY 40241
Phone: (502) 276-4706
www.medlifefit.com

Jessica Dowe, M.D., Ph.D., MBA

Lecresha Evans, SANE, WHNP, APRN, MSN
Laretta Dodson, APRN
Andrea Huey, APRN
Deborah Smith, APRN
Dana Smith, APRN

Name: ________________________________ Date of Birth: _______________ Today's Date:____________

Reason for Today's Visit: ____

Is your visit related to a work related injury? ☐No ☐Yes MVA? ☐No ☐Yes Other Injury? ☐No ☐Yes

If so, Date of Injury _______________________________

Prior Physician (Name, Address, Phone Number) ____

Pharmacy ____(____)____________

Name Address City State ZIP Phone

Current Medications (Include prescribed medications, over-the-counter, vitamins, sleep aids, laxatives etc.)

MEDICATION	DOSE	FREQUENCY TAKEN	MEDICATION	DOSE	FREQUENCY TAKEN

Allergies (Medicine, Food, Latex, etc.)/Reactions:____

____

____

Please list the dates of your last:

Bone Density	____________	Physical	____________	Hepatitis B shot	____________
Chest X-ray	____________	Pap Smear	____________	MMR Shot	____________
Colonoscopy	____________	Cholesterol test	____________	Pneumonia shot	____________
EKG	____________	TB skin test	____________	Shingles shot	____________
Mammogram	____________	Flu shot	____________	Tetanus shot	____________

Please Provide a List of Surgeries and Dates

Surgery	Date

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Name ____ Date of Birth: ________________

Have you ever had a blood transfusion? ___No ___ Yes If Yes, when: ____________________________________

Do you have an advanced directive? ___ Living Will Health Care Power of Attorney ___ Yes ___ No

Do you wear: ___ Glasses ___ Contacts ___ Hearing aid

Marital status: ___ Single ___ Married ___ Separated ___ Divorced ___ Widowed

___ Children # __________________________ ___ Pets ___________________________

Tobacco Usage: ___ Yes ___ Never ___ No ___ Stopped When: _____________________________________

Type: ___ Cigarettes _____Packs/day for # years____ ___Pipe ___ Cigar ___Chewing Tobacco ___ Snuff

Use of Alcohol: ___ No ___Occasionally ___Daily Amount? ________________________________

Do you drink caffeine? ___ Yes ___ No Type? ____________________________ Amount? _________________

Substance Abuse: ___ No ___ Occasionally ___Daily Type? ____________________________

Present Occupation: ____

If retired, what was your previous employment? ____

Are you on a special diet or supplement? ___ No ___ Yes What: _________________ How long: ___________

Do you exercise? ___ No ___ Yes Frequency: ___________________ Type: ______________________________

Do you have a tattoo or body piercing? ___ No ___ Yes When: ____

Do you have any special requests due to your religious practices/culture/values? ___ No ___Yes

___ Special Diet ___ Blood Transfusion ___ Other? Please list___________________________________

Explain above: ____

Present/Previous Health Problems: (For family boxes indicate mother, father, brother, sister, children)

	Self	Family		Self	Family
Stroke			Leg/Back/Neck Pain/specify		
Diabetes/type			Hiatal Hernia		
Heart Problems/type			Convulsions/Seizures		
Arthritis			Kidney Disease		
Breathing Problems/type			Phlebitis/Blood Clots		
High Blood Pressure			Depression/Mental Illness		
Cancer/type/location			HIV/AIDS/STDs		
Hepatitis			Bleeding Problems/type		
Thyroid/type			Other		

	Age (if living)	Age at Death (if deceased)	State of Health If not good, state reasons	Cause of Death
Mother				
Father				
Brother(s) No. Alive _____ Deceased _____				
Sister(s) No. Alive _____ Deceased _____				
Children No. Alive _____ Deceased _____				

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SYSTEMS REVIEW

A. GENERAL	**YES**	**NO**	**Comments:**
1. Do you worry about your health?			
2. Do you usually feel tired?			
3. Do you feel that stress is adversely affecting your health?			

B. SKIN *Have you noticed:*	**Yes**	**No**	**Comments**
1. Skin rashes or itching			
2. Growths on the skin			
3. Sores that do not heal			
4. Change in the color or size of moles			

C. Eyes *Have you noticed:*	**Yes**	**No**	**Comments**
1. Blurred vision			
2. Double vision			
3. Draining or itching eyes			
4. Pain in your eyes			

D. ENT *Have you noticed:*	**Yes**	**No**	**Comments**
1. Difficulty Hearing			
2. Ringing in your ears			
3. Nasal stuffiness or drainage			
4. Frequent or severe nosebleeds			
5. Mouth sores that do not heal			
6. Recurrent sinus infection			
7. Dentures, bridges, or caps			
8. Tooth/mouth problems that make it difficult for you to eat			

E. RESPIRATORY *Have you had:*	**Yes**	**No**	**Comments**
1. Difficulty breathing			
2. To sleep on more than one pillow #_____			
3. Waking up short of breath			
4. A constant cough			
5. Coughing up blood			
6. Wheezing in your chest			
7. Exposure to tuberculosis			
8. Recurrent history of bronchitis			
9. Recurrent history of pneumonia			

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F. CARDIOVASCULAR *Have you had:*	**Yes**	**No**	**Comments**
1. Pain/pressure in your chest, jaw, arm w/exercise			
2. Heart palpitations at rest or during exercise			
3. A previous heart murmur			
4. Swelling in your ankles			
5. Cramps/pain in legs with walking			
6. Changes in the color of your fingers or toes			
7. History of high blood pressure			
8. History of abnormal EKG			

G. MUSCULOSKELETAL *Have you had:*	**Yes**	**No**	**Comments**
1. Pain in joints (location)			
2. Swelling in joints (location)			
3. Morning stiffness in joints			
4. Pain in joints in cold weather			
5. Pain in lower back which interferes with activity			

H. GASTROINTESTINAL *Have you had*:	**Yes**	**No**	**Comments**
1. Any change in appetite			
2. Any weight changes recently			
3. Difficulty swallowing			
4. Abdominal or stomach pain or discomfort			
5. Food intolerances (to fatty, greasy, spicy foods)			
6. Vomiting of blood			
7. Black or tarry stools			
8. Blood in stools			
9. Diarrhea in the last 3 months			
10. Constipation on regular basis			
11. Regular use of laxatives			
12. Eat fewer than 2 meals per day			
13. On special diets or supplements			

I. NERVOUS SYSTEM *Have you had:*	**Yes**	**No**	**Comments**
1. Frequent or severe headaches			
2. Dizziness or lightheadedness			
3. Episodes of fainting			
4. Seizures or convulsions			
5. Difficulty remembering recent events			
6. Episodes of crying			
7. An urge to commit suicide			
8. Difficulty sleeping			
9. Frequent feelings of agitation or loss of control			
10. Tingling or numbness arms/legs			
11.Trouble speaking			
12. Difficulty w/balance, coordination or weakness			

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K. Genitourinary System *Have you had:*	**Yes**	**No**	**Comments**
1. Difficulty with urination			
2. Burning or pain with urination			
3. Hesitation with urination			
4. Getting up at night to urinate more than one time			
5. Blood in urine			
6. Loss of urine with cough/sneeze			
7. Problems with sexual function			
8. (Men) Prostate gland trouble			

J. GYN (WOMEN ONLY) *Have you had:*	**Yes**	**No**	**Comments**
1. Regular monthly periods (date last period:_____)			
2. Spotting/bleeding between your periods			
3. Heavy bleeding with your periods			
4. Pain or cramping with your periods			
5. Bloating/irritability before your period			
6. Use birth control (Form:___________________)			
7. Hot flashes			
8. Have you passed menopause (if yes when)			
9. Vaginal discharge			
Please describe			
10. Monthly breast self-exam			
11. Hormone therapy			
If yes, how long?___________________			
Number Pregnancies ______			
Number of Children Born Alive______			
Number of Miscarriages______			
Number of Stillborns______			
Number of C-sections______			
Number of Abortions______			
Complications with pregnancy(s)______			

Are you interested in serious weight loss? ☐ Yes ☐ No

Completed by:____

Relationship to Patient:____ Date _________________________

Disclaimer: In this practice it is important to know that Dr. Jessica Dowe and staff are Christians. Keep in mind that comments, concerns and advice may reflect this in conversations and are in no way intended to insult, offend or disrespect any patient. Likewise, the patient's own religious preference, if known, will be respected and patient care will not be compromised.