Sutter Gould Medical Foundation
A Sutter Health Affiliate
1409 E. Briggsmore Ave.
Modesto, CA 95355
(209) 550-4788

PATIENT LABEL

MRN#: _____
CODE: _____
D/SERVICE: _____
D/BIRTH: _____

GENERAL SURGERY NEW PATIENT QUESTIONNAIRE

❒ Reason for today's visit: _____ Your Age: _____

❒ Physician requesting this consultation visit: _____

❒ What symptoms are you having? _____

_____

❒ What do you do to make it feel better? _____

_____

❒ What things make it worse? _____

_____

❒ Date Symptoms began? _____

REVIEW SYSTEMS

❒ Please circle any of the following symptoms or problems you are currently experiencing:

Const:	Fatigue/Weak	Fever	Loss of Appetite	No Problem
CV:	Chest Pain	Leg Swelling	Palpitations	No Problem
Resp:	Cough	Wheezing	Shortness of Breath	No Problem
GI:	Nausea	Diarrhea	Constipation	No Problem
	Vomiting	Indigestion	Blood in Stools	
GU:	Nighttime Urination	Frequent Urination	Blood in Urine	No Problem
Muscular:	Joint Pain	Muscle Pain	Muscle Weakness	No Problem
Skin:	Rash	Dry Skin	Itching	No Problem
Neuro:	Dizziness	Seizures	Fainting	No Problem
	Numbness	Memory Loss		
Psych:	Depression	Anxiety		No Problem
Endo:	Hot Flashes	Insomnia	Weight Change	No Problem
	Temperature Intolerance			
Hemo:	Adenopathy	Easy Bruising	Bleeding disorder	No Problem

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PAST MEDICAL HISTORY

❒ Please circle if **you** currently have any of the following conditions.

Heart Problems Diabetes Asthma High Blood Pressure Stroke Depressior

Cancer Lung Problems Liver Problems Kidney Problems

What kind of Cancer? _____

❒ List any major surgeries **you** have had: _____

_____

❒ List all medications **you** are currently taking: _____

_____

_____

❒ Do **you** have any allergies to medications? _____

_____

FAMILY HISTORY

❒ Do any **family** members have any of the following conditions?

Diabetes Yes No Who? _____

Heart Problems Yes No Who? _____

High Blood Pressure Yes No Who? _____

Stroke Yes No Who? _____

Cancer Yes No Who? _____

What kind of Cancer? _____

SOCIAL HISTORY

Marital Status: ❒ Single ❒ Married ❒ Widowed ❒ Divorced

Do you have Children? ❒ Yes ❒ No How many? _____

Do you live alone? ❒ Yes ❒ No If no, who do you live with? _____

Occupation: _____ Hours: _____

Do you drink Alcohol? ❒ Yes ❒ No How much? _____

Do you Smoke? ❒ Yes ❒ No How much? _____

Do you use Drugs? ❒ Yes ❒ No

NURSES SECTION: P_____ BP _____ WT _____ HT _____

Physician Signature_____