

Queens Professional Medical Care

53-71 65th Place Maspeth, NY 11378

New Patient Health Questionnaire

Name: _____ Date: _____

DOB: _____ Age: _____ Rj qpg-aaaaaaaaaaaaaaaaaaaaa Egm aaaaaaaaaaaaaaaaaaaaaa

PLEASE NOTE: This is a confidential record of your medical history and will be kept in this office. Information contained here will not be released to any person except when you have authorized us to do so.

What medical concerns bring you to our office? _____

Marital Status: (circle) S M D W Occupation: (if retired, previous occupation) _____

If disabled, check here: _____ Nature of disability _____ Birthplace: _____

Do you exercise routinely? (circle) No Yes If Yes, what exercise/how often? _____

Have you ever smoked? (circle) No Yes Cigar Pipe Cigarettes If Yes: #cigarettes/day _____ #yrs. _____

If you have never smoked, skip this question: Do you still smoke now? (circle) No Yes If No, when did you quit? _____

Have you completed Advanced Directives or do you have a Living Will? (circle) No Yes Which? _____

Caffeine: Do you drink (circle) caffeinated coffee, teas or sodas regularly? (circle) No Yes #/day _____

Tell us a little about your home environment: (e.g. live alone, with family, single parent, house, apt., etc.) _____

Are you under a lot of pressure at work or at home? (circle) No Yes, Which? _____

Medical Information

Allergies: Are you allergic to any drugs? (circle) No Yes Please list: _____

Medications (list all medications you are taking regularly. Include over the counter, herbal or natural remedies.)

Medical Illnesses or Conditions (list any chronic conditions which you have been diagnosed to have)

Have you ever had or been diagnosed to have: (check box by all that apply)

Cataracts		Heart Disease		Ulcers		Anemia		Depression	
Glaucoma		Heart Murmur		Digestive Disorder		Bleeding Disorders		Frequent Infection	
Asthma		High Blood Pressure		Hemorrhoids		Bone or		Cancer (type)	
Allergies		Pneumonia		Kidney Disease		Joint Disease			
Stroke		TB/Lung Disease		Kidney Stone(s)		German Measles		High Cholesterol	
Seizures/Epilepsy		Pleurisy		Diabetes or		Rheumatic Fever		Prostate Enlargement	
Heart Attack or		Jaundice or		PreDiabetes		Chicken Pox			
Angina		Liver Disease		Thyroid Disease		Syphilis			

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Operations:

Please list any surgery and approximate year

Year	Surgery
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Hospitalizations:

Other than operations

Year	Reason	Hospital
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Family Medical History	Age	Health <i>(list significant illness)</i>	Age at Death	If deceased, cause	Comments
Father					
Mother					
Brothers or Sisters					
Spouse					
Children					

Has any blood relative ever had? *(check if Yes and indicate relationship)*

- | | | |
|--|---|--|
| <input type="checkbox"/> Alzheimer's _____ | <input type="checkbox"/> Heart Attack before age 55 _____ | <input type="checkbox"/> Alcoholism _____ |
| <input type="checkbox"/> Tuberculosis _____ | <input type="checkbox"/> Bleeding Disease _____ | <input type="checkbox"/> Mental Disorder _____ |
| <input type="checkbox"/> Diabetes _____ | <input type="checkbox"/> Stroke _____ | <input type="checkbox"/> Allergies _____ |
| <input type="checkbox"/> High Blood Pressure _____ | <input type="checkbox"/> Seizures _____ | <input type="checkbox"/> Asthma _____ |
| <input type="checkbox"/> Heart Disease _____ | <input type="checkbox"/> Depression/Suicide _____ | <input type="checkbox"/> Cancer _____ |

Immunizations *(check if Yes and indicate year of last injection)*

- | | | |
|--|---|--------------------------------------|
| <input type="checkbox"/> Influenza _____ | <input type="checkbox"/> Pneumonia _____ | <input type="checkbox"/> MMR _____ |
| <input type="checkbox"/> Tetanus _____ | <input type="checkbox"/> Hepatitis A or B _____ | <input type="checkbox"/> Other _____ |

Transfusions: Have you ever had a blood or plasma transfusion *(circle)* No Yes

Weight: What is your weight now? _____ One year ago? _____ Maximum? _____ When? _____

Females Only: Are you pregnant, planning a pregnancy or nursing a child? *(circle)* No Yes

Date of last menstrual period? _____

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TODAY'S DATE ___/___/___ MALE ___ FEMALE ___ DATE OF BIRTH ___/___/___

NAME _____ SS# _____

ADDRESS _____ PHONE# _____

CITY _____ STATE _____ ZIP CODE _____

CELL PHONE# _____ OTHER# _____

EMERGENCY CONTACT _____

EMERGENCY CONTACT# _____

SPOUSE'S NAME _____

REFERRED BY _____

*** PLEASE CHECK ALL THAT APPLY ***

ZIP _____ PHONE# _____

INSURANCE TYPE- COMP _____ NO FAULT _____ D.O.A. _____ PVT _____

INSURANCE CARRIER _____ EMPLOYER _____

ADDRESS _____ ADDRESS _____

CITY _____ CITY _____ STATE _____

STATE _____ ZIP _____

POLICY HOLDER _____ POLICY # _____

POLICY HOLDER D.O.B _____ GROUP # _____

SECONDARY INSURANCE _____

ADDRESS _____ CITY _____ ZIP _____

POLICY HOLDER _____ DOB ___/___/___ POLICY# _____

I HEREBY AUTHORIZE DR.PASSARELLI TO RELEASE SUCH INFORMATION TO SECURE MY INSURANCE BENEFITS. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR SERVICES NOT COVERED BY MY INSURANCE COMPANY.

PATIENTS SIGNATURE _____

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Patient Information Acknowledgement Form

I have read and fully understand Queens Professional Medical Care P.C. Notice of Information Practices. I understand that Queens Professional Medical Care P.C. may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to the treatment or payment, I understand that I have the right to restrict how my personal information is used and disclosed for treatment, payment and administrative operation if I notify the practice. I also understand that Queens Professional Medical Care P.C. will consider request for restriction on a case by case basis, but does not have to agree to request for restrictions.

I hereby consent to the use and disclosure of my personal health information for purposes as noted in Queens Professional Medical Care P.C. notice of information practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

Patient Name

Signature

Date

Received by:
