Newtown Medical
James L. Stewart, M.D.
Board Certified in Internal Medicine
Syed W. Rizvi, M.D.
Board Certified in Internal Medicine

New Patient Medical Questionnaire (1 of 5)

Name: _____ **Date:**_____ **Date of Birth:** _____

Instructions for patient to **Please Print.**

Past Medical History

Childhood

☐ Rheumatic Fever ☐ Meningitis ☐ X-Ray therapy to head or neck

☐ Seizures ☐ Mumps ☐ Measles ☐ Chicken Pox

☐ Other _____

Adult

☐ Anemia	☐ Asthma	☐ Thyroid disease	☐ Other lung disease
☐ Angina	☐ Heart Attack	☐ Sleep apnea	☐ Other heart conditions
☐ Ulcer	☐ Gastroesophageal reflux	☐ Hepatitis	☐ Other liver disease
☐ Irritable Bowel	☐ Colon polyps	☐ Kidney stones	☐ Other kidney disease
☐ Migraines	☐ Seizure	☐ Stroke/TIA	☐ Depression
☐ Prostate problems	☐ Diabetes	☐ High blood pressure	☐ High cholesterol

☐ Other metabolic disease: _____

☐ Cancer:_____

☐ Other medical problems: _____

Surgical History (Please include dates)

☐ Operations: _____

☐ Major Injuries:_____

For Women Only

Are you currently pregnant? ☐ Yes ☐ No

How many live births have you had?_____ List your age at each birth:_____

Have you passed through menopause (either surgically or naturally)? ☐ Yes ☐ No Age of menopause: _____

Are you currently using contraception? ☐ Yes ☐ No What type? _____

Allergies

☐ Medication:_____

☐ Food: _____

☐ Other:_____

3400-A Old Milton Parkway, Suite 200
Alpharetta, GA 30005
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www.newtownmed.com

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New Patient Medical Questionnaire (2 of 5)

Name: _____ **Date:**_____ **Date of Birth:** _____

Instructions for patient to **Please Print.**

Medications

Pharmacy Name: _____ Pharmacy Phone #:_____

☐ Current Medications and Dosage:_____

_____

_____

Which of the following do you take?

Vitamins:	☐ Occasionally	☐ Daily	**Naproxen:**	☐ Occasionally	☐ Daily
Antihistamines:	☐ Occasionally	☐ Daily	**Tylenol:**	☐ Occasionally	☐ Daily
Decongestants:	☐ Occasionally	☐ Dally	**ibuprofen:**	☐ Occasionally	☐ Daily
Herbs:	☐ Occasionally	☐ Daily	**Aspirin:**	☐ Occasionally	☐ Daily

Personal History

Highest educational level completed: ☐ High School ☐ Bachelor's Degree ☐ Master's Degree ☐ Doctorate Degree

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Employment: ☐ Employed ☐ Unemployed ☐ Retired ☐ Homemaker ☐ Student

Current Occupation:_____ Hours worked per week:_____

Are you happy with your employment? ☐ Yes ☐ No ☐ Somewhat

Previous Occupations: _____

Do you smoke? ☐ Cigarettes ☐ Cigars How many per day? _____ For how many years? _____

Previously smoked: ☐ Cigarettes ☐ Cigars How many per day? _____ When did you quit? _____

If you have never smoked, have you been exposed to second hand smoke on a regular basis? ☐ Yes ☐ No

Do you currently eat red meat? (beef, pork or lamb) ☐ Yes ☐ No How many times per week? _____

Do you drink alcohol? ☐ Yes ☐ No On average, how many servings per week? _____ In general, what do you drink? ☐ Beer ☐ Wine ☐ Liquor

Do you use recreational drugs? ☐ Never used ☐ Used in the past ☐ Currently use ☐ History of IV drug use

On average, how many times per week do you engage In physical activity for at least 20 minutes? _____

Type of activity:_____ Level of Intensity: ☐ Low ☐ Moderate ☐ High Childhood

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New Patient Medical Questionnaire (3 of 5)

Name: _____ **Date:**_____ **Date of Birth:** _____

Instructions for patient to **Please Print.**

Past Procedures

	Date	Results
☐ Sigmoidoscopy	_____	_____
☐ Colonoscopy	_____	_____
☐ Treadmill stress test	_____	_____
☐ Pap smear	_____	_____
☐ Colon X-ray	_____	_____
☐ Mammogram	_____	_____
☐ EGO (stomach scope)	_____	_____
☐ UGI (stomach x-ray)	_____	_____
☐ Echocardiogram	_____	_____
☐ Cardiac cauterization	_____	_____

Immunizations

☐ Tetanus _____ (date received) ☐ Pneumococcal _____ (date received)

☐ Hepatitis A _____ (date received) ☐ Hepatitis _____ (date received)

Current or Recent Complaints

Head

☐ Impaired sight ☐ Allergies ☐ Persistent hoarseness ☐ Impaired hearing ☐ Sore throat

Respiratory

☐ Cough ☐ Shortness of breath ☐ Wheezing ☐ Sputum production

Cardiac

☐ Chest discomfort ☐ Shortness of breath with exertion ☐ Shortness of breath If lying flat

☐ Palpitations ☐ Persistent swelling of feet or ankles

Gastrointestinal

☐ Heartburn ☐ Diarrhea ☐ Rectal bleeding ☐ Difficulty swallowing

☐ Abdominal pain ☐ Black tarry stools ☐ Constipation

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New Patient Medical Questionnaire (4 of 5)

Name: _____ **Date:**_____ **Date of Birth:** _____

Instructions for patient to **Please Print.**

Current or Recent Complaints (continued)

Genito-urinary

☐ Difficulty starting urination ☐ Narrowed urinary stream ☐ Up 3 times or more a night to urinate

☐ Blood in urine ☐ Problems with sexual function ☐ History of sexually transmitted diseases

Gynecological

☐ Irregular Periods ☐ Severe Cramps ☐ Unusually heavy bleeding ☐ Problems with bladder control ☐ Previous abnormal Pap smear

Hematologic

☐ Unusual bleeding or bruising

Neurologic

☐ Headaches ☐ Loss of coordination ☐ Arm or leg weakness ☐ Dizzy spells

☐ Numbness or tingling Where: _____

Musculoskeletal

☐ Back pain ☐ Joint pain ☐ Joint inflammation (redness, heat)

Endocrine

☐ Unusually hot natured ☐ Unusually cold natured ☐ Excessive thirst ☐ Excessive urination

General

☐ Anxiety ☐ Stress ☐ Fatigue ☐ Insomnia ☐ Unexplained weight loss ☐ Unexplained weight gain

Have you been told that you have pauses in your breathing during sleep? ☐ Yes ☐ No

Have you ever felt that you needed to cut down on your drinking? ☐ Yes ☐ No

Have people annoyed you by criticizing your drink? ☐ Yes ☐ No

Have you ever felt guilty about your drinking? ☐ Yes ☐ No

Have you ever had a drink in the morning to steady your nerves or get rid of a hangover? ☐ Yes ☐ No

Have you been bothered by feeling down, hopeless, or depressed? ☐ Yes ☐ No

Have you been bothered by having little interest or pleasure in doing things? ☐ Yes ☐ No

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New Patient Medical Questionnaire (5 of 5)

Name: _____ **Date:**_____ **Date of Birth:** _____

Instructions for patient to **Please Print.**

Family History

Complete the information about your blood relatives. Please exclude adoptive parents, siblings, or children.

Are you adopted? ☐ Yes ☐ No

Mother ☐ Alive ☐ Age: _____ ☐ Deceased Age at death: _____ Cause of death: _____

Father ☐ Alive ☐ Age: _____ ☐ Deceased Age at death: _____ Cause of death: _____

	Number alive	Ages	Number deceased	Age(s) at death	Cause(s) of death
Brothers					
Sisters					
Sons					
Daughters					

Mark the appropriate Illnesses/conditions you known have occurred in your family using the codes below.

M - Mother MGM - Maternal Grandmother MGF - Maternal Grandfather
F - Father PGM - Paternal Grandmother PGF - Paternal Grandfather
A - Aunt U - Uncle S-Sister B - Brother D - Daughter SO-Son

	Relative(s)	Approximate age(s) at diagnosis
Diabetes		
Coronary Heart Disease		
Stroke/TIA		
Colon Cancer		
Lung Cancer		
Prostate Cancer		
Breast Cancer		
Ovarian Cancer		
Thyroid Cancer		
High Blood Pressure		
High Cholesterol		
Liver disorder		
Alcohol/drug abuse		
Depression		
Tuberculosis		
Anesthesia complication		
Osteoporosis		
Hemochromatosis/iron overload		

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Piedmont Graphics 11/02/17