BASSI CLINIC
YOUR HEALTH.OUR PRIORITY

NEW PATIENT INTAKE QUESTIONNAIRE

Welcome to Bassi Clinic. Please fill out this form entirely and as accurately as possible. This information will help Dr. Bassi determine the best possible care for you. All information will be kept strictly confidential.

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

Main reason for your visit today (Chief complaint):

☐ **Establish Care** ☐ **Problem Visit** ☐ **Physical Exam** ☐ **Weight Loss**

Others: _____

_____

_____

_____

PERSONAL MEDICAL HISTORY

Please check all that applies

- ☐ Acid Reflux
- ☐ Anemia
- ☐ Aneurysm
- ☐ Anxiety Disorder
- ☐ Arrhythmia
- ☐ Asthma
- ☐ Arthritis
- ☐ Atrial Fibrillation
- ☐ Bleeding Disorder
- ☐ Blood Disorder
- ☐ Cancer
  Type: _____
- ☐ Celiac Disease
- ☐ Cirrhosis
- ☐ Chronic Bronchitis
- ☐ Congestive Heart Failure
- ☐ Constipation
- ☐ COPD
- ☐ Coronary Artery Disease
- ☐ DVT
- ☐ Dementia
- ☐ Depression
- ☐ Diabetes Mellitus T 1
- ☐ Diabetes Mellitus T 2
- ☐ Diverticulosis
- ☐ Diverticulitis
- ☐ Emphysema
- ☐ Erectile Dysfunction
- ☐ Eating Disorder
- ☐ Fibromyalgia
- ☐ Gallstone
- ☐ Glaucoma
- ☐ Gout
- ☐ Heart Attack/MI
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ Hemorrhoids
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ HIV/AIDS
- ☐ Irritable Bowel Syndrome
- ☐ Jaundice
- ☐ Kidney Problems/Failure
- ☐ Stones
- ☐ Liver Disease
- ☐ Lupus
- ☐ Migraine
- ☐ Mini Stroke/TIA
- ☐ Murmurs
- ☐ Osteopenia
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Pancreatitis
- ☐ Parkinson's

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- ☐ Pneumonia
- ☐ Polycystic Ovarian Syndrome
- ☐ Positive TB Test
- ☐ Prostate Problems
- ☐ Pulmonary Embolism
- ☐ Pulmonary Hypertension
- ☐ Restless Leg Syndrome
- ☐ Rheumatic Fever
- ☐ Rheumatoid Arthritis
- ☐ Sarcoidosis
- ☐ Seasonal Allergies
- ☐ Seizure Disorder
- ☐ Sinusitis
- ☐ Skin Problems
- ☐ Sleep Apnea
- ☐ Stomach Ulcers
- ☐ Stroke
- ☐ STD
- ☐ Thyroid Problems
- ☐ Tuberculosis
- ☐ Ulcerative Colitis
- ☐ Valley Fever
- ☐ Other:

_____
_____
_____
_____
_____
_____

ALLERGIES

Allergen/Drug	REACTION

MEDICATIONS

NAME, DOSAGE	
1.	**6.**
2.	**7.**
3.	**8.**
4.	**9.**
5.	**10.**

SURGICAL HISTORY

DATE	PROCEDURE

PAST HOSPITALIZATIONS

DATE	PROCEDURE

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FAMILY HISTORY

Father: ☐Alive ☐Deceased ☐Unknown Age: ____ Health Problems: _____

Mother:☐Alive ☐Deceased ☐Unknown Age: ____ Health Problems: _____

Other Family History:

_____
_____
_____
_____
_____
_____

SOCIAL HISTORY

Marital Status: ☐Single ☐Married ☐Divorced ☐Separated ☐Widowed Son/s: ____ Daughter/s____

Occupation:

Tobacco Use/Smoking:

- ○ Current Smoker
- ○ Current Every Day Smoker
- ○ Current Some Day Smoker
- ○ Smoker, Current Status Unknown
- ○ Former Smoker
- ○ Nonsmoker
- ○ Unknown If Ever Smoked
- ○ Light Tobacco Smoker
- ○ Heavy Tobacco Smoker
- ○ Uses Tobacco In Other Forms

If smoker, since when: _____ **If quit, when**: _____ **If restarted, since when**: _____

Alcohol Use: ☐1 – 2 ☐3 – 4 ☐5 – 6 ☐More than 6 ☐per day ☐per week ☐per month

Recreational Drug Use: ☐Yes, _____ ☐No

SPIRITUAL HISTORY

Religious Preference: ☐Yes, _____ ☐No

What relaxes you: _____

Do you meditate? ☐Yes, _____ ☐No

Have you tried alternative/complimentary therapy? ☐Yes, _____ ☐No

Sleep: ☐Uninterrupted ☐Disturbed Hours: _____ Schedule:_____

Physical Activity: Type: _____ Duration: _____ Frequency: _____ Intensity: _____

Type: _____ Duration: _____ Frequency: _____ Intensity: _____

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SEXUAL HISTORY

Are you sexually active? ☐Yes ☐No

Do you practice safe sex? ☐Yes ☐No

Do you use birth control? ☐Yes ☐No

Are you pregnant? ☐Yes, due date: _____ ☐No

Number of: Live Births: ___ Abortions____ Miscarriages _____

OTHER PROVIDERS:

	Name	Specialty	Phone Number
1.			
2.			
3.			
4.			
5.			
6.			

REVIEW OF SYSTEMS

Please check all that applies

GENERAL
- ☐ Fever
- ☐ Unusual tiredness
- ☐ Unexplained weight loss/gain
- ☐ Sleep disturbance

EYES
- ☐ Blurred, Double or loss of vision
- ☐ Red eye
- ☐ Eye pain

NECK
- ☐ Mass or swollen glands
- ☐ Goiter
- ☐ Pain/Stiffness

HORMONAL
- ☐ Excessive thirst
- ☐ Excessive sweating
- ☐ Excessive hunger

GASTROINTESTINAL
- ☐ Abdominal pain
- ☐ Nausea
- ☐ Vomiting
- ☐ Vomiting blood
- ☐ Diarrhea

HEAD
- ☐ Headaches
- ☐ Fainting spells
- ☐ Dizziness
- ☐ Seizures

EAR, NOSE, & THROAT
- ☐ Hearing loss
- ☐ Ringing in ears
- ☐ Frequent infections
- ☐ Ear pain
- ☐ Nasal congestion
- ☐ Nose bleeds
- ☐ Sore throat

RESPIRATORY
- ☐ Shortness of breath
- ☐ Dry cough
- ☐ Cough with phlegm
- ☐ Wheezing

CARDIAC
- ☐ Chest pain at rest
- ☐ Chest pain with exertion
- ☐ Palpitations

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- ☐ Constipation
- ☐ Blood in stool
- ☐ Dark stool
- ☐ Heartburn
- ☐ Last colonoscopy date _____,
  Result_____

GENITOURINARY

- ☐ Blood in urine
- ☐ Pain or Burning on urination
- ☐ Frequent urination
- ☐ Urgency of urination
- ☐ Hesitancy
- ☐ Difficulty urinating
- ☐ Urinary leakage

NEUROLOGICAL

- ☐ Imbalance
- ☐ Memory loss
- ☐ Arm/Leg weakness

BREASTS

- ☐ Lump
- ☐ Pain
- ☐ Nipple discharge

Any other concern not listed above: _____

_____

_____

_____

- ☐ Ankle/Leg swelling

MUSCOLOSKELETAL

- ☐ Joint pain
- ☐ Back pain
- ☐ Joint swelling

VASCULAR

- ☐ Cold hands or feet
- ☐ Leg pain on walking or at rest

SKIN

- ☐ Rash
- ☐ Moles
- ☐ Discoloration

PSYCHIATRIC

- ☐ Anxiety
- ☐ Depressed mood
- ☐ Suicidal thoughts
- ☐ Hallucinations

WOMEN ONLY

- ☐ Irregular menses
- ☐ Heavy menses
- ☐ Painful intercourse
- ☐ Vaginal discharge
- ☐ Using birth control
- ☐ On Hormone replacement
- ☐ Last Pap done on _____
- ☐ History of abnormal Pap
- ☐ History of abnormal Mammogram
- ☐ Last Menstrual period
  _____

I hereby certify that the above information is true and correct to the best of my knowledge.

Patient/Representative Name (Print): _____

Signature: _____ Date: _____/_____/_____