Boone Medical Group - Surgery
1601 E Broadway, Suite 240
Columbia, MO 65201
www.boone.health
Phone: 573.815.8145
Fax: 573.815.3832

NEW PATIENT QUESTIONAIRE

Today's Date:
Primary Care Provider:
Referring Provider:
Please list any other providers who you would like to receive a copy of your surgeon's notes/records from your visit?

Patient Information

Last Name:	First:	Middle:	Mr. Mrs.	Miss Ms.

Date of Birth: / /	Age:	SSN:	Sex: Male Female	(Former name):

Race:	Ethnicity:	Preferred Language:
☐ Black/African American ☐ White/Caucasian ☐ Native American ☐ Hispanic ☐ Asian ☐ Spanish American ☐ Other: ________________	☐ Hispanic or Latino ☐ Non-Hispanic/Latino ☐ Other ___________	☐ English ☐ French ☐ Spanish ☐ German ☐ Chinese ☐ Other:_______

Home Number: ( )	Cell Number: ( )	Work Number: ( )

Street Address:	City:	State:	ZIP Code:

E-mail Address:
Preferred Pharmacy & Location:

IN CASE OF EMERGENCY

Name of friend or relative:	Relationship to patient:	Home number: ( )	Cell/Work Number: ( )
Name of friend or relative:	Relationship to patient:	Home number: ( )	Cell/Work Number: ( )

Do you have a legal guardian ☐ Yes ☐ No
If yes, please list name and contact of you legal guardian: ____

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Patient Name: ___________________________ DOB: ______________ Date: _______________

MEDICATION		
Please provide a printed medication list or List all of your current medications, including over-the-counter and herbal supplements.		
☐ NO CURRENT MEDICATIONS		
Medication	**Dose**	**Frequency**
Please list any additional medications on the bottom of this sheet or on the back.		

ALLERGIES	
☐ **NO ALLERGIES**	
Medication:	Reaction:
Please list any additional allergies on the bottom of this sheet or on the back.	

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Patient Name: ___________________________ DOB: ______________ Date: _______________

PERSONAL MEDICAL HISTORY

Please mark if you have or have had any of the following medical conditions;
List any additional medical conditions which you feel your surgeon should be aware of:

☐ **NO MEDICAL HISTORY**

Anemia
Angina (chest pain)
Anxiety
Arthritis
Asthma
Atrial Fibrillation (A.Fib)
BPH (Prostate Problems)
Blood Clots
Cancer –Specify:
____
Celiac Disease
Cerebrovascular Accident (Stroke)
OTHER: ________________

COPD
Coronary Artery Disease (CAD)
Crohn's Disease
Depression
Diabetes
GERD (Acid Reflux)
Liver disease/ problems
High cholesterol
High blood pressure
Irritable Bowel Syndrome (IBS)
OTHER: ________________

Myocardial infarction (heart attack)
Osteoarthritis
Osteoporosis
Peptic Ulcer Disease
Renal Disease (Kidney Disease)
Seizure Disorder
Thyroid Disease
- Overactive
- Underactive

OTHER: ________________

PERSONAL SURGICAL HISTORY

Please list all prior surgeries and the approximate month/year they took place:

☐ **NO PAST SURGICAL HISTORY**

Appendectomy, Yr ____
Back Surgery, Yr ____
Breast Surgery, Yr ____
Type: _______________
Cardiac Surgery, Yr ____
Type: _______________
Carpal Tunnel, Yr ____
Colon Surgery, Yr ____
Cystoscopy, Yr ____
C-Section, Yr ____
Eye Surgery, Yr ____

Hernia Repair, Yr ____
Type: _______________
Gallbladder, Yr ____
Kidney Removal, Yr ____
Hip Replacement ---
LEFT OR RIGHT, Yr ____
Hysterectomy, Yr ____
Kidney Stone, Yr ___
Knee Surgery;
LEFT OR RIGHT, Yr ___
Knee Replacement;
LEFT OR RIGHT, Yr ___

Pacemaker, Yr ____
Shoulder Surgery
LEFT OR RIGHT, Yr ___
Tonsils/Adenoids, Yr ____
Tubal Ligation, Yr ____
Other: ________________
- Yr _____

Other: ________________
- Yr _____

Other: ________________
- Yr _____

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FAMILY MEDICAL HISTORY

Relationship	Arthritis	Asthma	COPD	Diabetes	Early Death (Before age 60)	Deafness	Heart Disease	High Cholesterol	High Blood Pressure	Kidney Disease	Mental Illness (Depression/Anxiety)	Mental Retardation	Stroke	Blindness	Breast Cancer	Colon Cancer	Stomach Cancer	Cancer - Specify	A.Fib	Liver Disease	Seizures	Other	Other
Mother																							
Father																							
Sister																							
Brother																							
Daugther																							
Son																							
Maternal G-mother																							
Maternal G-father																							
Paternal G-mother																							
Paternal G-father																							

SOCIAL HISTORY

Marital Status: Single / Married / Divorced / Separated / Widowed	Children: ☐ YES ☐ NO Number of Children: _________
Employment Status: Full-time / Part-Time / Self Employed / Retired / Not employed	
Employer:	Occupation:
Do you use tobacco? ☐ YES ☐ NO ☐ IN THE PAST __Cigarette __Cigars __Vapor __Chew	Do you drink alcohol? ☐ YES ☐ NO ☐ IN THE PAST How many drinks per week? _________
Do you use recreational drugs? ☐ YES ☐ NO ☐ IN THE PAST TYPE: ____________________	Are you sexually active? ☐ YES ☐ NO Do you use contraception? TYPE: _____________

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General Review of Systems

Please read carefully below and check the box if you are currently having any of these symptoms:

NOT CURRENTLY HAVING ANY OF THE LISTED SYMPTOMS

Chills
Fatigue
Fever

Rash
Itching

Ear Pain
Eye Pain
Sore Throat

Chest Pain
Chest Palpitations
Leg Swelling

Cough
Shortness of Breath
Wheezing

Nausea
Vomiting
Abdominal pain

Diarrhea
Constipation
Blood in stool

Pain with Urination
Blood in Urine
Urinary Urgency
Urinary Frequency

Back Pain
Neck Pain
Muscle Weakness

Easy Bleeding
Easy Bruising

Dizziness
Seizures
Headache
Tremors

Anxiety
Depression
Trouble sleeping (insomnia)