The Mount Sinai Medical Center

THE PROGRAM FOR DIAGNOSTIC AND PREVENTIVE MEDICINE

Date:________________

Dear______________________:

Welcome to The Mount Sinai Program for Diagnostic and Preventive Medicine.

You are scheduled to meet with Dr. __________________on (day)____________(date) __________ at (time) _____________. If for any reason you are unable to keep this appointment, please let us know as soon as possible. Our office is located on Fifth Avenue at 100th street, entry level.

Please return the following items to us in advance of your visit:

(1) medical records you think may be relevant, including reports of any testing carried out within the past year

(2) the attached questionnaire, completed as best you can

(3) a list of particular questions you would like the doctor to answer.

Sincerely,

The Program for
Diagnostic and Preventive Medicine

FIFTH AVENUE AT 100TH STREET ♦ NEW YORK, NY 10029 ♦ TELEPHONE (212) 241-8000 ♦ FACSIMILE (212) 831-2195

PATIENT INFORMATION

A Physician: ______________________ Date of Visit: ______________

Please complete the following:

Name of patient (if indicated incorrectly): ______________________

Address: ______________________

Telephone: Day ( ) ______________ Evening ( ) ______________

Email address: ______________ Fax: ( ) ______________

Social Security Number: ______________________

Date of Birth: ______________________

Birthplace: ______________________

Mount Sinai Unit Number (if available): ______________________

Are you employed? Yes No Retired? Yes No

Occupation: ______________________

Who should be contacted regarding appointments and other matters?

Self: Other person: ______________________

Marital status: Married Single Divorced Widowed

Have you signed an Advanced Healthcare Directive? ______________________

Who can be contacted in case of an emergency? ______________________

Name: ______________________

Address: ______________________

Telephone: Day ( ) ______________ Evening ( ) ______________

Relationship to you: ______________________

B Please list the names and telephone numbers of others involved in your care:

Physician	Specialty	Address	Telephone	✔ Receive Report

C Are you currently under a physician's care for any ailment or injury? Yes ☐ No ☐

Why have you scheduled an appointment with the doctor at this time, and what are your expectations?

____

____

____

D Are you taking any prescription medications? Yes ☐ No ☐ *(If no skip to next)*

Please have these available at your visit.

Name of Medication	Dosage	Frequency	Any Side Effects?

E Are you taking any OTC/non-prescription medications? Yes ☐ No ☐ *(If no skip to next)*

Name of Medication	Dosage	Frequency	Any Side Effects?

F Are you taking any vitamins, homeopathics, herbal medicines or supplements? Yes ☐ No ☐
(If no skip to next)

Name of Supplement	Dosage	Freqency	Any Side Effects?

G Have you ever had a bad reaction to any medication or supplement? Yes ☐ No ☐ Not Sure ☐

Name of Medication / Supplement	Reaction

H Are you allergic to any other substances? Yes ☐ No ☐ Not Sure ☐
(If no skip to next section)

Name of Medication / Supplement	Reaction

I **CONSTITUTIONAL/SYSTEMIC:**

What is your current weight? ______________ lbs
What is your height? ______________ lbs
What is the least you have weighed in the past 5 years? ______________ lbs
What is the most you have weighed in the past 5 years? ______________ lbs
Have you had recent unexplained weight gain? Yes ☐ No ☐
Have you had recent unexplained weight loss? Yes ☐ No ☐
How many hours do you sleep on average at night? ______________ hours
Are you frequently tired? Yes ☐ No ☐
Are you having trouble sleeping? Yes ☐ No ☐
If yes, please explain: ______________
Have you had recent fevers, night sweats or chills? Yes ☐ No ☐
Do you regularly use a seatbelt in automobiles? Yes ☐ No ☐

MEDICAL HISTORY

Please do not leave urgent information on this form.
If you need medical advice or are not sure what type of care you need, please call 1-800-MD-SINAI

A

Have you had any major illnesses or surgeries? Yes No

Condition	Year	Where Treated

B LIFESTYLE

a.) Have you ever smoked cigarettes? Yes No
How many years have you smoked? ______
How many packs per day? ______
If you have quit, what year did you quit? ______
Have you used tobacco in other forms (pipe, cigars, chew)? Yes No
Are you exposed to "second-hand" smoke? Yes No

b.) Do you drink alcoholic beverages? Yes No
How many drinks per day? ______
Do you have or do others express concerns about your drinking? ______

Do you drink coffee or tea? Yes No
What are your hobbies? Yes No
Do you have any pets or animals? Yes No
Have you lived outside the United States? Yes No
Have you or your family recently experienced any life changes or unusual psychological stress? Yes No

C DIET AND NUTRITION

a.) Please characterize your current diet, describing your typical breakfast, lunch and dinner:

______

b.) Do you have intolerance of any particular foods (lactose, gluten, etc.)?

______

D EXCERCISE

a.) Do you exercise regularly? Yes No

b.) What type of exercise and how often?

____

____

c.) Do you know of any health reason that should limited you from participating in physical activity?
Yes No Not Sure

Explain: ______________________________________

____

E FAMILY MEDICAL HISTORY

	Living	Deceased	Age	Major Illnesses / Cause of Death
Mother				
Father				
Maternal Grandmother				
Maternal Grandfather				
Paternal Grandmother				
Paternal Grandfather				
Sisters, Brothers (please specify):				
Aunts, Uncles (please specify):				
Children (please specify):				

F Have you had the following immunizations?

- Pneumonia Vaccine Year: ____________
- Tuberculin (TB) skin test Year: ____________
- Diptheria/Tetanus Year: ____________
- Hepatitis A (2 shot series) Year: ____________
- Influeza ("flu") Year: ____________
- BCG (to prevent TB) Year: ____________
- Measles/Mumps/Rubella Year: ____________
- Hepatitis B (3 shot series) Year: ____________

Have you traveled recently or plan to travel in the immmediate future? ____________

G Have you ever had or tested positive for:

- Chicken Pox
- Tuberculosis
- HIV
- Hepatitis: Type: ____________
- Venereal (sexually transmitted) disease: Specify: ____________

H Other tests:

	Date	Result
Chest X-Ray:		
Cholesterol Level:		
Triglyceride Level:		
Other Lipid Data:		
Colonoscopy:		
Mammogram:		
Pap Test:		
Bone Density Test:		

SYMPTOM REVIEW

A ENDOCRINE/GLANDULAR

Do you suffer from:

Feeling hot or cold all the time	Yes	No	Not Sure
Thyroid problems or goiter	Yes	No	Not Sure
Diabetes	Yes	No	Not Sure
Excessive thirst	Yes	No	Not Sure
Hyperthyroidism	Yes	No	Not Sure
Hyperparathyroidism	Yes	No	Not Sure
Testosterone deficiency	Yes	No	Not Sure
Cushing's syndrome	Yes	No	Not Sure
Treatment with: steroids (prednisone etc)?	Yes	No	Not Sure
Intestinal disease, malabsorption	Yes	No	Not Sure
Gaucher's disease	Yes	No	Not Sure

B DERMATOLOGIC/SKIN

Do you suffer with:

Skin trouble or rash	Yes	No	Not Sure
Flushing	Yes	No	Not Sure
Change in hair or nails	Yes	No	Not Sure

C HEENT

Do you suffer with:

Headache or migraine	Yes	No	Not Sure
Eye or vision problem	Yes	No	Not Sure
Eyeglasses or contact lenses?			
If so, when was your most recent change in lens prescription?			
Have you had a LASIK or other corrective eye surgery?	Yes	No	Not Sure
Have you ever had any other surgeries of your eyes?	Yes	No	Not Sure
Have you had cataracts or surgery to correct cataracts?	Yes	No	Not Sure
Have you had glaucoma?	Yes	No	Not Sure
Nose congestion or sinus trouble	Yes	No	Not Sure
Ear or hearing problem	Yes	No	Not Sure
Dental (tooth) problems	Yes	No	Not Sure
Dental plate, bridgework, or false teeth	Yes	No	Not Sure
Gingival (gum) problems or bleeding	Yes	No	Not Sure
Temporomandibular joint (TMJ) problems	Yes	No	Not Sure
Sore throat	Yes	No	Not Sure
Postnasal drip or secretions	Yes	No	Not Sure
Swollen lymph nodes	Yes	No	Not Sure

D BREASTS

Do you have:

Breast cancer or a lump	Yes	No	Not Sure
Pain, tenderness or discharge	Yes	No	Not Sure

E RESPIRATORY/LUNGS

Do you:

Have a cough	Yes	No	Not Sure
Have wheezing or shortness of breath	Yes	No	Not Sure
Snore	Yes	No	Not Sure
Have tuberculosis or pneumonia	Yes	No	Not Sure
Blood in sputum	Yes	No	Not Sure

F CARDIOVASCULAR

Do you have:

Chest pain or tightness	Yes	No	Not Sure
Palpitations (skipped beats)	Yes	No	Not Sure
Swollen legs or feet	Yes	No	Not Sure
Hypertension (high blood pressure)	Yes	No	Not Sure
Hyperlipidemia (cholesterol, etc.)	Yes	No	Not Sure
Heart attack, angina	Yes	No	Not Sure
Heart murmur	Yes	No	Not Sure
Rheumatic fever	Yes	No	Not Sure
Claudication or leg pain on walking	Yes	No	Not Sure
Blood clots or "phlebitis"	Yes	No	Not Sure
Varicose veins	Yes	No	Not Sure

G ABDOMINAL/DIGESTIVE

Do you have:

Abdominal pain	Yes	No	Not Sure
Nausea or vomiting	Yes	No	Not Sure
Bloating, gas or indigestion	Yes	No	Not Sure
Heartburn	Yes	No	Not Sure
Ulcer	Yes	No	Not Sure
Difficulty swallowing	Yes	No	Not Sure
Jaundice	Yes	No	Not Sure
Liver disease	Yes	No	Not Sure
Gallbladder problems	Yes	No	Not Sure
Pancreatitis	Yes	No	Not Sure
Change in bowel habits	Yes	No	Not Sure
Black or bloody stool	Yes	No	Not Sure
Colon Cancer or Colon Polyps	Yes	No	Not Sure
Hemorrhoids	Yes	No	Not Sure

H GENITAL/URINARY

Do you have:

Urinary problems (pain or frequency)	Yes	No	Not Sure
Blood in urine	Yes	No	Not Sure
Kidney stones	Yes	No	Not Sure
Urinary infections	Yes	No	Not Sure
Sexual dysfunction	Yes	No	Not Sure
Do you use a contraceptive?	Yes	No	Not Sure

I MUSKULOSKELETAL

Do you have:

Joint or muscle pains or stiffness that limit mobility	Yes	No	Not Sure
Joint swelling, redness or deformity	Yes	No	Not Sure
Back pain	Yes	No	Not Sure
Fracture	Yes	No	Not Sure
Implanted plates, pins or screws	Yes	No	Not Sure
Osteoporosis	Yes	No	Not Sure

J NEUROLOGICAL

Have you had or do you have:

Numbness or muscle weakness	Yes	No	Not Sure
Temporary loss of vision, speech or strength	Yes	No	Not Sure
Loss of consciousness (black-out spells)	Yes	No	Not Sure
Dizziness of lightheadedness	Yes	No	Not Sure
Impaired memory or confusion	Yes	No	Not Sure
Difficulty concentrating	Yes	No	Not Sure
A stroke	Yes	No	Not Sure
Panic attacks	Yes	No	Not Sure
Epilepsy or seizures	Yes	No	Not Sure

K FOR MEN

Do you have:

Prostate problems?	Yes	No	Not Sure
Pain or lump in scrotum or testicles	Yes	No	Not Sure
Impaired libido (sex drive)	Yes	No	Not Sure
Difficulty with ejaculation	Yes	No	Not Sure
Discharge from penis	Yes	No	Not Sure

Other tests:

	Date	Result
Prostate exam:		
PSA level:		

L

FOR WOMEN

Could you be pregnant? Yes No Not Sure

Are you still having menstrual periods? Yes No Not Sure

At what age did your menstrual periods begin? ______

Number of pregnancies ______

Number of live births ______

Miscarriages______

If you no longer have periods:

At what age did they stop? ______

Do you experience hot flashes? Yes No Not Sure

Do you experience vaginal dryness? Yes No Not Sure

Have you had any bleeding since menopause? Yes No Not Sure

If you still have menstrual periods:

How often do they occur? ______

How many days do your periods last? ______

When did your last period begin? ______

Do you have severe cramps? Yes No Not Sure

Do you have PMS/moodiness? Yes No Not Sure

Do you spot/bleed between menstrual periods? Yes No Not Sure

Do you have any vagina discharge Yes No Not Sure

Have you ever taken birth control pills? Yes No Not Sure

Have you ever had an abnormal PAP smear? Yes No Not Sure

Do you perform breast self-examination? Yes No Not Sure

Other tests:

	Date	Result
Mammogram		
Pap test:		
Bone density test:		

Are you taking medication forOsteoporosis?

	✔	Date Began	Result
Estrogen			
Fosamax			
Evista			
Miacalcin			
Actonel			
Calcium			
Vitamin D			

HAVE WE COVERED EVERYTHING?

Please enter any other information about your health that you would like the physician to know or address: