



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

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: _____

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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?

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F Are you taking any vitamins, homeopathics, herbal medicines or supplements? Yes No

(If no skip to next)

Name of Supplement	Dosage	Frequency	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*

Condition *Year* *Where Treated*

Condition *Year* *Where Treated*

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 EXERCISE

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?

- | | | | |
|--|-------------|--|-------------|
| <input type="checkbox"/> Pneumonia Vaccine | Year: _____ | <input type="checkbox"/> Influeza (“flu”) | Year: _____ |
| <input type="checkbox"/> Tuberculin (TB) skin test | Year: _____ | <input type="checkbox"/> BCG (to prevent TB) | Year: _____ |
| <input type="checkbox"/> Diphtheria/Tetanus | Year: _____ | <input type="checkbox"/> Measles/Mumps/Rubella | Year: _____ |
| <input type="checkbox"/> Hepatitis A (2 shot series) | Year: _____ | <input type="checkbox"/> Hepatitis B (3 shot series) | Year: _____ |

Have you traveled recently or plan to travel in the immediate 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 <input type="checkbox"/>	No <input type="checkbox"/>	Not Sure <input type="checkbox"/>
Thyroid problems or goiter	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Not Sure <input type="checkbox"/>
Diabetes	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Not Sure <input type="checkbox"/>
Excessive thirst	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Not Sure <input type="checkbox"/>
Hyperthyroidism	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Not Sure <input type="checkbox"/>
Hyperparathyroidism	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Not Sure <input type="checkbox"/>
Testosterone deficiency	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Not Sure <input type="checkbox"/>
Cushing's syndrome	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Not Sure <input type="checkbox"/>
Treatment with: steroids (prednisone etc)?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Not Sure <input type="checkbox"/>
Intestinal disease, malabsorption	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Not Sure <input type="checkbox"/>
Gaucher's disease	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Not Sure <input type="checkbox"/>

B DERMATOLOGIC/SKIN

Do you suffer with:

Skin trouble or rash	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Not Sure <input type="checkbox"/>
Flushing	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Not Sure <input type="checkbox"/>
Change in hair or nails	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Not Sure <input type="checkbox"/>

C HEENT

Do you suffer with:

Headache or migraine	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Not Sure <input type="checkbox"/>
Eye or vision problem	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Not Sure <input type="checkbox"/>
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 <input type="checkbox"/>	No <input type="checkbox"/>	Not Sure <input type="checkbox"/>
Have you ever had any other surgeries of your eyes?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Not Sure <input type="checkbox"/>
Have you had cataracts or surgery to correct cataracts?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Not Sure <input type="checkbox"/>
Have you had glaucoma?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Not Sure <input type="checkbox"/>
Nose congestion or sinus trouble	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Not Sure <input type="checkbox"/>
Ear or hearing problem	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Not Sure <input type="checkbox"/>
Dental (tooth) problems	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Not Sure <input type="checkbox"/>
Dental plate, bridgework, or false teeth	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Not Sure <input type="checkbox"/>
Gingival (gum) problems or bleeding	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Not Sure <input type="checkbox"/>
Temporomandibular joint (TMJ) problems	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Not Sure <input type="checkbox"/>
Sore throat	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Not Sure <input type="checkbox"/>
Postnasal drip or secretions	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Not Sure <input type="checkbox"/>
Swollen lymph nodes	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Not Sure <input type="checkbox"/>

D BREASTS

Do you have:

- | | | | |
|-------------------------------|------------------------------|-----------------------------|-----------------------------------|
| Breast cancer or a lump | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Not Sure <input type="checkbox"/> |
| Pain, tenderness or discharge | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Not Sure <input type="checkbox"/> |

E RESPIRATORY/LUNGS

Do you:

- | | | | |
|--------------------------------------|------------------------------|-----------------------------|-----------------------------------|
| Have a cough | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Not Sure <input type="checkbox"/> |
| Have wheezing or shortness of breath | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Not Sure <input type="checkbox"/> |
| Snore | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Not Sure <input type="checkbox"/> |
| Have tuberculosis or pneumonia | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Not Sure <input type="checkbox"/> |
| Blood in sputum | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Not Sure <input type="checkbox"/> |

F CARDIOVASCULAR

Do you have:

- | | | | |
|-------------------------------------|------------------------------|-----------------------------|-----------------------------------|
| Chest pain or tightness | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Not Sure <input type="checkbox"/> |
| Palpitations (skipped beats) | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Not Sure <input type="checkbox"/> |
| Swollen legs or feet | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Not Sure <input type="checkbox"/> |
| Hypertension (high blood pressure) | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Not Sure <input type="checkbox"/> |
| Hyperlipidemia (cholesterol, etc.) | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Not Sure <input type="checkbox"/> |
| Heart attack, angina | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Not Sure <input type="checkbox"/> |
| Heart murmur | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Not Sure <input type="checkbox"/> |
| Rheumatic fever | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Not Sure <input type="checkbox"/> |
| Claudication or leg pain on walking | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Not Sure <input type="checkbox"/> |
| Blood clots or “phlebitis” | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Not Sure <input type="checkbox"/> |
| Varicose veins | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Not Sure <input type="checkbox"/> |

G ABDOMINAL/DIGESTIVE

Do you have:

- | | | | |
|------------------------------|------------------------------|-----------------------------|-----------------------------------|
| Abdominal pain | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Not Sure <input type="checkbox"/> |
| Nausea or vomiting | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Not Sure <input type="checkbox"/> |
| Bloating, gas or indigestion | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Not Sure <input type="checkbox"/> |
| Heartburn | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Not Sure <input type="checkbox"/> |
| Ulcer | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Not Sure <input type="checkbox"/> |
| Difficulty swallowing | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Not Sure <input type="checkbox"/> |
| Jaundice | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Not Sure <input type="checkbox"/> |
| Liver disease | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Not Sure <input type="checkbox"/> |
| Gallbladder problems | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Not Sure <input type="checkbox"/> |
| Pancreatitis | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Not Sure <input type="checkbox"/> |
| Change in bowel habits | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Not Sure <input type="checkbox"/> |
| Black or bloody stool | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Not Sure <input type="checkbox"/> |
| Colon Cancer or Colon Polyps | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Not Sure <input type="checkbox"/> |
| Hemorrhoids | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Not Sure <input type="checkbox"/> |

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 or 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 for Osteoporosis?

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

