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
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:

<table>
<thead>
<tr>
<th>Physician</th>
<th>Specialty</th>
<th>Address</th>
<th>Telephone</th>
<th>Receive Report</th>
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</thead>
<tbody>
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</table>

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.

<table>
<thead>
<tr>
<th>Name of Medication</th>
<th>Dosage</th>
<th>Frequency</th>
<th>Any Side Effects?</th>
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<tbody>
<tr>
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E. Are you taking any OTC/non-prescription medications?  
Yes  [ ]  No  [ ]  (If no skip to next)

<table>
<thead>
<tr>
<th>Name of Medication</th>
<th>Dosage</th>
<th>Frequency</th>
<th>Any Side Effects?</th>
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</table>
F
Are you taking any vitamins, homeopathics, herbal medicines or supplements? Yes □ No □
(If no skip to next)

<table>
<thead>
<tr>
<th>Name of Supplement</th>
<th>Dosage</th>
<th>Frequency</th>
<th>Any Side Effects?</th>
</tr>
</thead>
<tbody>
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</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Name of Medication / Supplement</th>
<th>Reaction</th>
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H
Are you allergic to any other substances? Yes □ No □ Not Sure □
(If no skip to next section)

<table>
<thead>
<tr>
<th>Name of Medication / Supplement</th>
<th>Reaction</th>
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<tbody>
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</table>

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 ☐

<table>
<thead>
<tr>
<th>Condition</th>
<th>Year</th>
<th>Where Treated</th>
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</table>

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

<table>
<thead>
<tr>
<th>Relative</th>
<th>Living</th>
<th>Deceased</th>
<th>Age</th>
<th>Major Illnesses / Cause of Death</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mother</td>
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</tr>
<tr>
<td>Father</td>
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<tr>
<td>Maternal Grandmother</td>
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<td>Maternal Grandfather</td>
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<tr>
<td>Paternal Grandfather</td>
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<tr>
<td>Sisters, Brothers (please specify):</td>
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<tr>
<td>Aunts, Uncles (please specify):</td>
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<tr>
<td>Children (please specify):</td>
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</tbody>
</table>
Have you had the following immunizations?

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

Have you traveled recently or plan to travel in the immediate future? ________________________________________________

Have you ever had or tested positive for:

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

Other tests:

<table>
<thead>
<tr>
<th>Test</th>
<th>Date</th>
<th>Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chest X-Ray:</td>
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<tr>
<td>Cholesterol Level:</td>
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<tr>
<td>Triglyceride Level:</td>
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<tr>
<td>Other Lipid Data:</td>
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<tr>
<td>Colonoscopy:</td>
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<tr>
<td>Mammogram:</td>
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<tr>
<td>Pap Test:</td>
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<tr>
<td>Bone Density Test:</td>
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</tbody>
</table>
Symptom Review

A  ENDOCRINE/GLANDULAR
Do you suffer from:
- Feeling hot or cold all the time
- Thyroid problems or goiter
- Diabetes
- Excessive thirst
- Hyperthyroidism
- Hyperparathyroidism
- Testosterone deficiency
- Cushing's syndrome
- Treatment with: steroids (prednisone etc)?
- Intestinal disease, malabsorption
- Gaucher's disease

B  DERMATOLOGIC/SKIN
Do you suffer with:
- Skin trouble or rash
- Flushing
- Change in hair or nails

C  HEENT
Do you suffer with:
- Headache or migraine
- Eye or vision problem
  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?
- Have you ever had any other surgeries of your eyes?
- Have you had cataracts or surgery to correct cataracts?
- Have you had glaucoma?
- Nose congestion or sinus trouble
- Ear or hearing problem
- Dental (tooth) problems
- Dental plate, bridgework, or false teeth
- Gingival (gum) problems or bleeding
- Temporomandibular joint (TMJ) problems
- Sore throat
- Postnasal drip or secretions
- Swollen lymph nodes
# Program for Diagnostic and Preventive Medicine

## Breasts

**Do you have:**
- Breast cancer or a lump
  - Yes □  No □  Not Sure □
- Pain, tenderness or discharge
  - Yes □  No □  Not Sure □

## 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 □

## 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 □

## 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 □
## GENITAL/URINARY

**Do you have:**
- Urinary problems (pain or frequency)
- Blood in urine
- Kidney stones
- Urinary infections
- Sexual dysfunction
- Do you use a contraceptive?

## MUSKULOSKELETAL

**Do you have:**
- Joint or muscle pains or stiffness that limit mobility
- Joint swelling, redness or deformity
- Back pain
- Fracture
- Implanted plates, pins or screws
- Osteoporosis

## NEUROLOGICAL

**Have you had or do you have:**
- Numbness or muscle weakness
- Temporary loss of vision, speech or strength
- Loss of consciousness (black-out spells)
- Dizziness of lightheadedness
- Impaired memory or confusion
- Difficulty concentrating
- A stroke
- Panic attacks
- Epilepsy or seizures

## FOR MEN

**Do you have:**
- Prostate problems?
- Pain or lump in scrotum or testicles
- Impaired libido (sex drive)
- Difficulty with ejaculation
- Discharge from penis

**Other tests:**

<table>
<thead>
<tr>
<th>Prostate exam:</th>
<th>Date</th>
<th>Result</th>
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</thead>
<tbody>
<tr>
<td>PSA level:</td>
<td></td>
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</tbody>
</table>
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:

<table>
<thead>
<tr>
<th>Test</th>
<th>Date</th>
<th>Result</th>
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<tbody>
<tr>
<td>Mammogram</td>
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<tr>
<td>Pap test</td>
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<tr>
<td>Bone density test</td>
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</table>

Are you taking medication for Osteoporosis?

<table>
<thead>
<tr>
<th>Medication</th>
<th>Date Began</th>
<th>Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>Estrogen</td>
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<tr>
<td>Fosamax</td>
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<td>Evista</td>
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<td>Miacalcin</td>
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<td>Actonel</td>
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<td>Calcium</td>
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<tr>
<td>Vitamin D</td>
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HAVE WE COVERED EVERYTHING?

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

________________________________________________________________________

________________________________________________________________________

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