UCLA Health

MRN:
Patient Name:

(Patient Label)

PATIENT QUESTIONNAIRE
UCLA CENTER FOR EAST – WEST MEDICINE

Welcome to the UCLA Center for East- West Medicine Primary Care

Instructions:

We ask a lot of questions because we *really* want to get to know you! Please take your time with the paper work and return it to your doctor as soon as you can. We look forward to meeting you!

Medical History:

1) Please list any medical conditions that you have:

2) Please list any surgical or medical procedures you have had in the past:

3) Please list all medications, herbs, supplements, vitamins or over the counter products that you are using:

4) Do you have any allergies or “bad reactions” to any medications? Do you have any food sensitivities or intolerance?

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5) What medical conditions run in your family (heart disease, cancer, etc?)? Please list the medical conditions and the age that your family member was diagnosed:

Mother: _____

Father: _____

Any other family members: _____

6) Have you had any of the following vaccinations? If you have, when was your last vaccination?

- ☐ Influenza vaccine
- ☐ Pertussis vaccine
- ☐ Tetanus vaccine
- ☐ Pneumonia vaccine
- ☐ Zoster vaccine (Shingles)
- ☐ Hepatitis B vaccine
- ☐ Hepatitis A vaccine
- ☐ HPV/Gardasil vaccine

7) Have you ever had any of the following screening tests? If you have, please let us know when you last had the screening test and what you remember about the results.

- ☐ HIV test
- ☐ Hepatitis B or C test
- ☐ Mammogram
- ☐ Colonoscopy
- ☐ Pap smear
- ☐ Abdominal Ultrasound for aortic aneurysm
- ☐ PSA test
- ☐ Bone density scan

8) Do you think you may be pregnant?

- ☐ Yes
- ☐ No

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How have you been feeling? :

1) Please check if you are experiencing any of the following:

- ☐ Daily Fatigue
- ☐ Weight Loss
- ☐ Weight Gain
- ☐ Fever
- ☐ Night sweats
- ☐ Restless Legs
- ☐ Rash
- ☐ Nail Changes
- ☐ Cough
- ☐ Difficulty Breathing
- ☐ Blurred vision
- ☐ Dry Eyes
- ☐ Eye Pain
- ☐ Nausea
- ☐ Diarrhea
- ☐ Constipation
- ☐ Abdominal Pain
- ☐ Heart Burn
- ☐ Excessive Thirst
- ☐ Feeling hot all the time
- ☐ Feeling cold all the time
- ☐ Excessive Urination
- ☐ Burning with Urination
- ☐ Blood in Urine
- ☐ Blood in Stool
- ☐ Unusual vaginal bleeding
- ☐ Pain with Intercourse
- ☐ Leaking Urine
- ☐ Skin lesions that worry you
- ☐ New Lump
- ☐ Chest Pain
- ☐ Palpitations
- ☐ Easy Bruising
- ☐ Headaches
- ☐ Dizziness
- ☐ Numbness / Tingling (please state where)

  _____
- ☐ Fear of Falling
- ☐ Unsteady Walking
- ☐ Frequent Infections
- ☐ Runny Nose
- ☐ Red Eyes
- ☐ Snoring
- ☐ Choking or Gasping in sleep
- ☐ Trouble swallowing
- ☐ Memory Difficulties

2) How would you rate the quality of your sleep on a 1 – 10 scale (1 being terrible and 10 being completely restful)? If you have trouble sleeping let us know if you have trouble falling asleep or wake up frequently.

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

3) In the last two weeks how often have you felt: (check what applies to you)

Little interest in doing things:

☐ Never ☐ Several days ☐ More than half the days ☐ Nearly every day

Feeling down or depressed:

☐ Never ☐ Several days ☐ More than half the days ☐ Nearly every day

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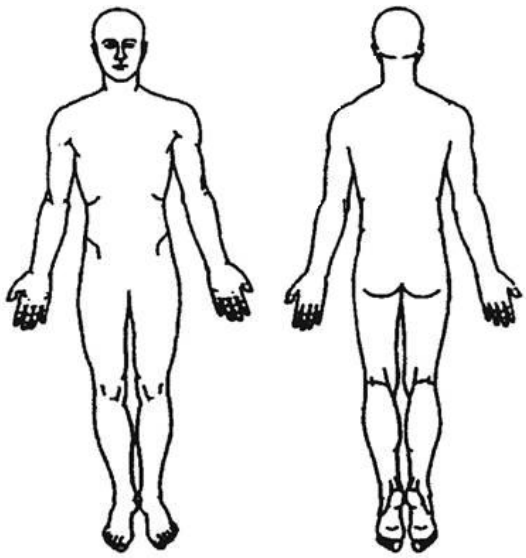
4) Do you have pain or muscle tightness anywhere? Mark with an X the areas that bother you.
Please rate the severity of pain on a scale of 0 – 10
(0 being no pain and 10 being absolutely awful)



Your Life:

1) What do you do for your profession? _____

_____

2) Who do you live with? _____

_____

3) What do you do for exercise and how often do you do it? _____

_____

4) How often do you do any of the following?

- ☐ Smoke Cigarettes? _____
- ☐ Drink Alcohol? _____
- ☐ Smoke Marijuana? _____
- ☐ Any other drugs? (please list them) _____

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5) Who are the other health care practitioners in your life? Please don't forget to include acupuncturists, massage therapists, or anyone else that you have a healing relationship with.

_____

_____

6) Everyone has stress.
1. Where does the stress in your life come from (work, home, etc)? _____
2. What do you do to relax and let go? _____
3. Please rate the stress you have been feeling lately on a scale from 0 – 10
(0 being no stress and 10 being extreme stress)

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Your Goals:

Feeling well is central to a productive and active life. Please take some time to think of three wellness goals you have for yourself. We will work on these goals as a team to make them happen.

_____

_____

_____

Examples of goals: 1) Decrease my knee pain so that I can walk daily 2) Lose weight 3) try to decrease the number of medications I take every morning.

1. _____

_____

2. _____

_____

3. _____

_____

Is there anything else that you think is important for your new doctor to know about you?

_____

_____

_____

_____

_____

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Thank you so much for taking the time to fill out this form! We look forward to working with you.

If you finish your questionnaire before your first appointment, please send it in! We would love the chance to review your history and your goals before your first appointment. If not, then please remember to bring it when you come to visit us.

You can fax it: 310–829–9318

You can mail it:

UCLA Center for East–West Medicine
2336 Santa Monica Blvd., Suite 301
Santa Monica, CA 90404

As with any doctor visit, it is important to remember to bring your insurance card and photo ID with you to clinic.

Patient or Representative Signature _____ Date _____ Time _____

If signed by someone other than the patient, please specify relationship to the patient: _____

Interpreter Signature _____ Date _____ Time _____

Physician Signature _____ ID # _____ Date _____ Time _____