NPA
Northwest Physicians Associates

www.northwestphysicians.com

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Dear _____,

You have an appointment on: _____@_____AM / PM

We welcome you to Northwest Physicians Associates, P.C. and the office of Julie Knapka, CRNP.

We ask that you please take some time to **review and complete** the following forms and bring them to your first appointment.

All information will be confidential and will assist us in getting to know you better.

The addresses, phone, and fax numbers are listed above. Please call if you need additional directions to the office for your visit.

Please plan to arrive **30 minutes** prior to your scheduled appointment to ensure a timely check-in process, OR YOU WILL BE RESCHEDULED!

Thank you!

PATIENT QUESTIONNAIRRE

Please take a few minutes to give us the following information. It will assist us in getting to know you better. Thank you.

Name: _____ Date of birth: _____ Date: _____

Height: _____ Weight: _____ Reason for your visit today: _____

Preferred Pharmacies: LOCAL:_____ MAIL ORDER:_____

*PAST MEDICAL HISTORY

Please check if you have NOW, or ever have had any of the following:

☐ Adrenal Tumor	☐ Epilepsy	☐ HYPERthyroidism
☐ Asthma	☐ Fractured Bones	☐ Kidney Disease
☐ Anemia	Type: _____	☐ Kidney Stones
☐ Cancer	☐ Goiter	☐ Osteoporosis
Type: _____	☐ Heart Problems	☐ Pituitary Tumor or Surgery
☐ Cataract	☐ Coronary Disease	☐ Pneumonia
☐ Childhood neck irradiation	☐ High Cholesterol	☐ Stroke
☐ Depression	☐ HYPOthyroidism	☐ Stomach ulcers
☐ Diabetes	☐ Hypertension	☐ Other _____

Other Significant Illness/Injury _____

_____

*__ALLERGIES*__

Previous Operations or Surgeries	**Year**	DRUG	REACTION
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

I have had a pneumonia vaccine ☐ yes 1x☐ 2x☐ I get a flu shot each fall ☐ yes ☐ no

*FAMILY HISTORY

☐ ADOPTED

MEMBER:	**HEALTH PROBLEMS:**	**MEMBER:**	**HEALTH PROBLEMS:**
MOTHER	_____	MAT. GRANDMOTHER	_____
FATHER	_____	MAT. GRANDFATHER	_____
BROTHERS	_____	PAT. GRANDMOTHER	_____
SISTERS	_____	PAT. GRANDFATHER	_____
CHILDREN	_____	1ST DEGREE RELATIVES	_____

Do other family members not listed above have any of the following:

☐ Diabetes ☐ Heart Disease ☐ High Cholesterol ☐ Hypertension ☐ Strokes
☐ Thyroid Disease ☐ Kidney Stones ☐ Osteoporosis ☐ Hormone Problems

REVIEW OF SYSTEMS

Please check off any of the problems that apply to you **CURRENTLY**.

GENERAL
- ☐ Fatigue
- ☐ Weight Gain
- ☐ Weight Loss

SKIN
- ☐ Brittle Nails
- ☐ Dryness
- ☐ Excessive Sweating
- ☐ Excessive Hair Growth
- ☐ Hair loss
- ☐ Hump in upper back
- ☐ Skin Color Changes
- ☐ Stretch Marks

EYES/NOSE/MOUTH/THROAT
- ☐ Blurred Vision
- ☐ Double Vision
- ☐ Excessive Tearing
- ☐ Dry eyes
- ☐ Eye pain
- ☐ Eye redness
- ☐ Vision loss
- ☐
- ☐ Hoarseness
- ☐ Voice Changes
- ☐ Dry Mouth
- ☐ Decreased sense of smell
- ☐ Dysphagia (difficulty swallowing)

NECK
- ☐ Enlarged thyroid
- ☐ Neck lump
- ☐ Neck pain
- ☐ Swollen glands

RESPIRATORY
- ☐ Cough
- ☐ Decreased exercise tolerance
- ☐ Shortness of breath

BREAST
- ☐ Breast mass
- ☐ Gynecomastia (breast enlargement)
- ☐ Nipple discharge

CARDIOVASCULAR
- ☐ Chest pain
- ☐ Fainting
- ☐ Irregular heartbeat
- ☐ Night cramps
- ☐ Palpitations
- ☐ Rapid heart rate
- ☐ Swelling of extremities

GASTROINTESTINAL
- ☐ Abdominal pain
- ☐ Constipation
- ☐ Diarrhea
- ☐ Difficulty swallowing
- ☐ Get full quickly at meals
- ☐ Heartburn
- ☐ Nausea
- ☐ Vomiting
- ☐ Hyperphagia (increased appetite)

FEMALE GENITOURINARY

Age at start of periods _____

Age at menopause _____

Last Menstrual Period_____
- ☐ Absence of menstruation
- ☐ Dysmenorrheal (painful periods)
- ☐ Excessive menstrual bleeding
- ☐ Frequent urination
- ☐ Menstrual irregularities
- ☐ Polyuria (excessive urination)
- ☐ Urinating at night
- ☐ Vaginal dryness

MALE GENITOURINARY
- ☐ Change in urinary stream
- ☐ Frequent Urination
- ☐ Impotence
- ☐ Polyuria (excessive urination)
- ☐ Urinating at night

MUSCULOSKELETAL
- ☐ Calf pain/cramps on exertion
- ☐ Leg cramps
- ☐ Muscle cramps
- ☐ Muscle weakness

NEUROLOGICAL
- ☐ Decreased memory
- ☐ Dizziness
- ☐ Headaches
- ☐ Parathesis (abnormal sensation)
- ☐ Tremor
- ☐ Visual changes

PSYCHIATRIC
- ☐ Anxiety
- ☐ Depression
- ☐ Inability to concentrate
- ☐ Insomnia
- ☐ Mood changes

ENDOCRINE
- ☐ Appetite changes
- ☐ Cold Intolerance
- ☐ Excessive sweating
- ☐ Excessive thirst
- ☐ Heat intolerance
- ☐ Hot flashes
- ☐ Libido change (sex drive)
- ☐ Sexual dysfunction

*Social History

☐ Married ☐ Divorced ☐ Widowed ☐ Single

Who do you live with? _____

Children? _____

Occupation:_____ Hrs/week ___ Active ☐ yes ☐ no Stressful ☐ yes ☐ no

*Smoking History ☐ yes ☐ no Amount ____ Date quit____ Amt/years smoked ____

*Alcohol use ☐ yes ☐ no Frequency _____

*Illicit drug use ☐ yes ☐ no

*Caffeine intake _____ servings/day (coffee, tea, sodas, etc.)

*Exercise ☐ yes ☐ no Type: _____ Frequency: _____

*Diet type: ☐ Regular ☐ Low Cholesterol ☐ Low Salt ☐ Diabetic Calories _____

Time of meals and schedule

Arise _____ Bkfst _____ Lunch _____ Supper _____ Snacks _____

*CURRENT MEDICATIONS

MEDICATION	DOSE	TIMES/DAY	**MEDICATION**	DOSE	TIMES/DAY

If you have Diabetes, please complete the following:

☐ Type 1 @ age ___ ☐ Type 2 @ age ___ ☐ Gestational/during pregnancy

I check my blood sugar ____ times/day with _____meter type. My blood sugars have been averaging _____@ breakfast, _____ @ lunch, _____ @ supper, and _____ at bedtime.

INSULIN USERS: Daily Dose is _____

Insulin PUMP users: Basal rates: _____

Insulin to carb ratio: 1 unit for ____ grams of carbs. ___ all meals ___bkfst ___ lunch ___supper

Sensitivity: 1 unit drops me ____ points. Blood Sugar Goals _____ Pump name: _____

History of diabetic ketoacidosis ☐ yes ☐ no Last Hemoglobin A1c ____% on _____(date)

DIABETES COMPLICATIONS: (check those that apply)

☐ Retinopathy Last eye exam date: _____ by Dr: _____. Laser treatment? ☐ yes ☐ no

Nerve problem in: ☐ hands ☐ feet ☐ bladder ☐ stomach (slow)

☐ Heart attack ☐ Stroke ☐ Kidney problems (Specialist Dr. _____)

☐ I have NOT had a diabetic class ☐ I have had a diabetic class ☐ I need a diabetic class

The patient and I have reviewed the pages on this questionnaire. _____

doctor or nurse practitioner

If you are diabetic, please bring a list of your blood sugars with you