



BROWN SURGICAL ASSOCIATES
BROWN PHYSICIANS, INC.

Brown Surgical Associates General and Bariatric Surgery

New Patient Questionnaire:

*Please complete this questionnaire and bring it with you to your appointment with the practitioner.
This information will assist us in your care plan. Thank you.*

Full Name: _____ **Date of Birth:** _____

Gender: _____ Female _____ Male

Address: _____

City, State, Zip: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____

Email: _____

Race: (please circle all that apply)

African-American Asian Caucasian Hispanic Pacific Islander/Hawaiian
Native American Other: _____

What are you here for today? _____

Surgeon Requested (if known): _____

Hospital Requested (if known): _____

How did you hear about our program? My physician _____ A friend _____

Facebook Internet Northwell's Website Brochure Newspaper Other _____

Primary Care/Family Physician: _____

Practice Name: _____

Address: _____ City, State, Zip: _____

Office Phone: _____ Office Fax: _____

Referring Physician (if different from above): _____

Practice Name: _____

Address: _____ City, State, Zip: _____

Office Phone: _____ Office Fax: _____



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Please indicate if you are now experiencing or in the past year experienced any of the symptoms listed below.

<p>GENERAL</p> <p><input type="checkbox"/> Weight Gain</p> <p><input type="checkbox"/> Weight Loss</p> <p><input type="checkbox"/> Fever</p> <p><input type="checkbox"/> Chills</p> <p><input type="checkbox"/> Night Sweats</p> <p><input type="checkbox"/> Fatigue</p> <p>HEAD, EARS, EYES, NOSE, THROAT</p> <p><input type="checkbox"/> Eye Pain</p> <p><input type="checkbox"/> Red Eyes</p> <p><input type="checkbox"/> Dry Eyes</p> <p><input type="checkbox"/> Vision Problems</p> <p><input type="checkbox"/> Trouble Swallowing</p> <p><input type="checkbox"/> Pain with Swallowing</p> <p><input type="checkbox"/> Hearing Loss</p> <p><input type="checkbox"/> Nose Bleeds</p> <p><input type="checkbox"/> Dry Mouth</p> <p>Sore Throat</p> <p><input type="checkbox"/> Hoarseness</p> <p><input type="checkbox"/> Swollen Nodes</p>	<p>CARDIO-VASCULAR</p> <p><input type="checkbox"/> Chest Pain</p> <p><input type="checkbox"/> Palpitations</p> <p><input type="checkbox"/> Light Headedness</p> <p><input type="checkbox"/> Leg pain with exercise</p> <p><input type="checkbox"/> Leg swelling</p> <p>RESPIRATORY</p> <p><input type="checkbox"/> Shortness of Breath</p> <p><input type="checkbox"/> Wheezing</p> <p><input type="checkbox"/> Cough</p> <p><input type="checkbox"/> Painful Breathing</p> <p><input type="checkbox"/> Shortness of breath</p> <p><input type="checkbox"/> With activity</p> <p><input type="checkbox"/> Sleep Apnea</p> <p>GASTRO-INTESTINAL</p> <p><input type="checkbox"/> Abdominal Pain</p> <p><input type="checkbox"/> Heartburn/Reflux</p> <p><input type="checkbox"/> Nausea/Vomiting</p> <p><input type="checkbox"/> Hernia</p> <p><input type="checkbox"/> Constipation</p> <p><input type="checkbox"/> Diarrhea</p>	<p>RENAL/REPRODUCTIVE</p> <p><input type="checkbox"/> Painful Urination</p> <p><input type="checkbox"/> incontinence</p> <p><input type="checkbox"/> Vaginal Discharge</p> <p><input type="checkbox"/> Abnormal Vaginal Bleeding</p> <p>MUSCULOSKELETAL</p> <p><input type="checkbox"/> Joint Pain</p> <p><input type="checkbox"/> Joint Stiffness</p> <p><input type="checkbox"/> Back Pain</p> <p><input type="checkbox"/> Muscle Pain</p> <p><input type="checkbox"/> Muscle Weakness</p> <p>SKIN</p> <p><input type="checkbox"/> Rashes</p> <p><input type="checkbox"/> Skin wound</p>	<p>NEUROLOGIC</p> <p><input type="checkbox"/> Confusion</p> <p><input type="checkbox"/> Dizziness</p> <p><input type="checkbox"/> Fainting</p> <p><input type="checkbox"/> Difficulty walking</p> <p>PSYCH</p> <p><input type="checkbox"/> Suicidal</p> <p><input type="checkbox"/> Insomnia</p> <p><input type="checkbox"/> Anxiety</p> <p><input type="checkbox"/> Depression</p> <p>ENDOCRINE</p> <p><input type="checkbox"/> Bulging eyes</p> <p><input type="checkbox"/> Hot Flashes</p> <p><input type="checkbox"/> Muscle Weakness</p> <p><input type="checkbox"/> Voice Change</p> <p>HEME</p> <p><input type="checkbox"/> Easy Bleeding</p> <p><input type="checkbox"/> Easy Bruising</p> <p><input type="checkbox"/> Swollen Glands</p>
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Medical History: Please indicate if you have been diagnosed with any of the following illnesses:

<p><input type="checkbox"/> Heart Attack</p> <p><input type="checkbox"/> Cardiac Failure</p> <p><input type="checkbox"/> Coronary Disease</p> <p><input type="checkbox"/> High Blood Pressure</p> <p><input type="checkbox"/> High Cholesterol</p> <p><input type="checkbox"/> High triglycerides</p> <p><input type="checkbox"/> Obesity</p> <p><input type="checkbox"/> Constipation</p>	<p><input type="checkbox"/> COPD (lung disease)</p> <p><input type="checkbox"/> Asthma</p> <p><input type="checkbox"/> Sleep Apnea</p> <p><input type="checkbox"/> Emphysema</p> <p><input type="checkbox"/> Reflux/GERD</p> <p><input type="checkbox"/> Stomach ulcers</p> <p><input type="checkbox"/> Hiatal Hernia</p> <p><input type="checkbox"/> Abdominal Hernia</p> <p><input type="checkbox"/> Swallowing trouble</p>	<p><input type="checkbox"/> Achalasia</p> <p><input type="checkbox"/> Small Bowel Obstruction</p> <p><input type="checkbox"/> Hypothyroid</p> <p><input type="checkbox"/> Hyperthyroid</p> <p><input type="checkbox"/> Type 1 Diabetes</p> <p><input type="checkbox"/> Type 2 Diabetes</p> <p><input type="checkbox"/> Autoimmune Disease</p>	<p><input type="checkbox"/> Epilepsy/Seizures</p> <p><input type="checkbox"/> Neurological Disease</p> <p><input type="checkbox"/> Depression</p> <p><input type="checkbox"/> Anxiety</p> <p><input type="checkbox"/> Arthritis</p> <p><input type="checkbox"/> Cancer</p> <p>Type: _____</p>
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Please indicate any other illnesses or medical history:



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Surgical History

Please indicate any previous surgeries:

Do you have pain that interferes with your daily activity? No Yes

If yes, where is the pain? _____

Please circle the number that represents your pain level:

No pain 0 1 2 3 4 5 6 7 8 9 10 Severe pain

Social History

Employment Status: Full Time Part Time Self Employed Retired Unemployed
 Homemaker Student Disabled Not Specified

Occupation: _____ Employer: _____

Marital Status (please circle one): Single Married Separated Divorced Widowed Partnered

Do you have children/how many? _____

Do you use?		If YES, how much/often?
Tobacco/Nicotine products (<i>cigarettes, pipes, cigars, chewing tobacco, e cigarettes, vapes, nicotine patches/gums/lozenges, Chantix</i>)	YES NO	_____ packs per day for _____ years If you quit, when? _____
Alcohol	YES NO	Type: _____ Frequency: _____
Recreational Drugs (<i>opioids, marijuana, cocaine, heroin, etc.</i>)	YES NO	Type: _____ Frequency: _____



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Medications and Supplements:

Medication/Supplement	Dosage & Frequency	Reason

Allergies

Medication/Food	Reaction
Other Allergies	Reaction

Do you exercise regularly? Yes No

Types of exercise? Strengthening Cardio Other: _____

How often? _____ times/week _____ times/month

If no, what prevents you from exercising? Time Work Health Other: _____



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COVID Status

Have you had COVID? Yes (Date): _____ No

Have you been vaccinated for COVID? Yes (Date): _____ No

Family History

Please specify if you have any family members with:

Obesity _____

Heart Disease _____

Diabetes/Endocrine _____

High Blood Pressure _____

Cancer _____ Type: _____

Arthritis _____

Early Death _____

Asthma _____

Stroke _____

Depression _____ Other

Diseases _____