University of California
San Francisco
advancing health worldwide™

HHT CENTER OF EXCELLENCE
NEW PATIENT QUESTIONNAIRE

DATE: _____

PATIENT INFORMATION

PATIENT NAME: _____ **Date of Birth:** _____

ADDRESS:_____

HOME PHONE: _____ **WORK PHONE:** _____ **CELL PHONE:** _____

EMERGENCY CONTACT NAME:_____ **PHONE:**_____

MOTHER'S MAIDEN NAME: _____ **FATHER'S NAME:**_____

EMAIL ADDRESS: _____

INSURANCE INFORMATION/PRIMARY

INSURANCE CARRIER: _____ **MEMBER ID#:** _____ **GROUP #:** _____

ADDRESS: _____

PHONE #: _____ **SUBSCRIBER NAME:** _____

INSURANCE INFORMATION/SECONDARY

INSURANCE CARRIER: _____ **MEMBER ID#:** _____ **GROUP #:** _____

ADDRESS: _____

PHONE #: _____ **SUBSCRIBER NAME:** _____

REFERRING PHYSICIAN:

NAME: _____ **SPECIALTY:** _____

ADDRESS:_____

PHONE: _____ **FAX:** _____

PRIMARY CARE PHYSICIAN:

NAME: _____ **SPECIALTY:** _____

ADDRESS:_____

PHONE: _____ **FAX:** _____

ADDITIONAL PHYSICIANS YOU WOULD LIKE YOUR RECORDS TO BE SENT TO:

NAME: _____ SPECIALTY: _____

ADDRESS:_____

PHONE: _____ FAX: _____

NAME: _____ SPECIALTY: _____

ADDRESS:_____

PHONE: _____ FAX: _____

NAME: _____ SPECIALTY: _____

ADDRESS:_____

PHONE: _____ FAX: _____

HHT FOUNDATION REFERRAL: ☐ yes ☐ no

ALLERGIES:

Drug	Reaction
_____	_____
_____	_____
_____	_____

OTHER ALLERGOES:

Contrast/Iodine	☐ yes	☐ no
Latex	☐ yes	☐ no
Shellfish	☐ yes	☐ no

MEDICATIONS:

Drug	Dosage

PAST MEDICAL HISTORY:

Medical Diagnosis/Condition	Date of Diagnosis

PAST SURGICAL HISTORY:

Type of Surgery	Date of Surgery
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

SOCIAL HISTORY:

Smoking History ☐ yes ☐ no

Packs per day: _____ How Long: _____ Year Quit: _____

Alcohol: _____ Drinks per Day: _____ Type of Alcohol: _____

Drug Use: _____ Type: _____ Frequency: _____ Last Used: _____

FAMILY HISTORY:

Relative	Age	Health problems	Course of Death
Mother	_____	_____	_____
Father	_____	_____	_____
Maternal Grandmother	_____	_____	_____
Maternal Grandfather	_____	_____	_____
Paternal Grandmother	_____	_____	_____
Paternal Grandfather	_____	_____	_____
Sibling	_____	_____	_____
Sibling	_____	_____	_____
Sibling	_____	_____	_____
Sibling	_____	_____	_____
Child	_____	_____	_____
Child	_____	_____	_____
Child	_____	_____	_____
Child	_____	_____	_____

REVIEW OF SYSTEMS: Please check any that apply

GENERAL/CONSTITUTIONAL

- ☐ Fever
- ☐ Fatigue
- ☐ Weakness
- ☐ Weight gain
- ☐ Weight loss

HEAD, EYES, EARS, NOSE AND THROAT

- ☐ Eye pain
- ☐ Eye redness
- ☐ Loss of vision
- ☐ Double vision
- ☐ Blurred vision
- ☐ Flashing lights or spots
- ☐ Eye dryness
- ☐ Ringing in the ears
- ☐ Loss of hearing
- ☐ Nosebleeds
- ☐ Loss of sense of smell
- ☐ Dry sinuses
- ☐ Sinusitis
- ☐ Post nasal drip
- ☐ Sore tongue
- ☐ Bleeding gums
- ☐ Sores in the mouth
- ☐ Loss of sense of taste
- ☐ Dry mouth
- ☐ Dentures or removable dental work
- ☐ Frequent sore throats
- ☐ Hoarseness or constant need to clear the throat
- ☐ Waking up with acid or bitter fluid in the mouth or throat
- ☐ Food sticking in throat when swallow
- ☐ Painful swallowing
- ☐ **Telangiectasia of the nose**

CARDIOVASCULAR

- ☐ Chest pain
- ☐ Irregular heartbeats
- ☐ Sudden changes in heartbeat
- ☐ Palpitation
- ☐ Pacemaker
- ☐ Defibrillator
- ☐ Shortness of breath
- ☐ Difficulty breathing at night
- ☐ Swollen legs or feet
- ☐ Heart murmurs
- ☐ High blood pressure
- ☐ Cramps in legs
- ☐ Varicose veins

RESPIRATORY:

- ☐ Chronic dry cough
- ☐ Coughing up blood,
- ☐ Coughing up mucus
- ☐ Waking at night
- ☐ coughing or choking
- ☐ Repeated pneumonias
- ☐ Wheezing
- ☐ Night sweats
- ☐ **Lung AVMs**

GASTROINTESTINAL:

- ☐ Decreased appetite
- ☐ Nausea
- ☐ Vomiting
- ☐ Vomiting blood or coffee ground material
- ☐ Heartburn,
- ☐ Regurgitation
- ☐ Frequent belching
- ☐ Stomach pain
- ☐ Yellow jaundice
- ☐ Diarrhea
- ☐ Constipation
- ☐ Gas
- ☐ Blood in the stool
- ☐ Black tarry stools
- ☐ Hemorrhoids
- ☐ **GI tract AVMs**
- ☐ **Liver AVMs**

GENITOURINARY:

- ☐ Difficult urination
- ☐ Pain or burning with urination
- ☐ Blood in the urine
- ☐ Cloudy or smoky urine
- ☐ Urinary frequency
- ☐ Urinary urgency
- ☐ Needing to urinate frequently at night
- ☐ Inability to hold the urine
- ☐ Discharge from the penis
- ☐ Kidney stones
- ☐ Rash or ulcers
- ☐ Sexual difficulties
- ☐ Impotence or prostate trouble
- ☐ Sexually transmitted diseases

MUSCULOSKELETAL:

- ☐ Arm/buttock/thigh/calf cramps
- ☐ Joint or muscle pain
- ☐ Muscle weakness/tenderness
- ☐ Joint swelling
- ☐ Neck pain
- ☐ Back pain
- ☐ Major orthopedic injuries

SKIN AND BREASTS:

- ☐ Easy bruising
- ☐ Skin redness
- ☐ Skin rash
- ☐ Hives
- ☐ Sensitivity to sun exposure
- ☐ Nodules or bumps
- ☐ Hair loss
- ☐ Color changes in the hands or feet with cold
- ☐ Breast lump
- ☐ Breast pain
- ☐ Nipple discharge
- ☐ **Telangiectasia of the skin**

NEUROLOGIC:

- ☐ Confusion
- ☐ Difficulty concentrating
- ☐ Memory loss
- ☐ Dizziness
- ☐ Seizures
- ☐ Loss of consciousness
- ☐ Fainting spells
- ☐ Headaches
- ☐ Migraines
- ☐ Facial numbness/tingling
- ☐ Difficulty with speech
- ☐ Blurred vision
- ☐ Double vision
- ☐ Sensitivity or pain in the hands and feet
- ☐ Stroke/TIA
- ☐ **Brain AVMs**

PSYCHIATRIC:

- ☐ Depression
- ☐ Thoughts of suicide
- ☐ Hallucinations
- ☐ Received psychiatric counseling or treatment

ENDOCRINE:

- ☐ Intolerance to hot or cold
- ☐ Flushing
- ☐ Fingernail changes
- ☐ Increased thirst
- ☐ Increased salt intake
- ☐ Decreased sexual desire

HEMATOLOGIC/LYMPHATIC:

- ☐ Anemia
- ☐ Bruise easily
- ☐ Bleeding tendency
- ☐ Clotting tendency

ALLERGIC/IMMUNOLOGIC:

- ☐ Rhinitis
- ☐ Asthma
- ☐ Skin sensitivity
- ☐ Latex allergies or sensitivity

Diagnostic Test/Records	**Have you had this test?**
Chest X-Ray	**DATE**
Brain-MRI with Contrast	**DATE**
CT Chest	**DATE**
MRI/CT/US Liver	**DATE**
Blood Test-	
CBC w Differential	**DATE**
Comprehensive Metabolic Panel	**DATE**
Ferritin	**DATE**
PT/PTT	**DATE**
Agitated Saline/Bubble Echo	**DATE**
GI-Endoscopy	**DATE**
GI-Capsule Endoscopy	**DATE**
GI-Colonoscopy	**DATE**
Genetic Testing	**DATE**

Please send medical records, completed New Patient Questionnaire, and a copy of your insurance card to the below address. Medical records should include the results and films from the above tests, recent physical, hospital admission, and recent surgeries.

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